INTRODUCTION TO YOUR INDIVIDUAL ADVANTAGE CONTRACT

Welcome and thank you for choosing **Aetna** for your health benefits. We are pleased to provide you with this **Contract**. This **Contract** and other plan documents describe what is covered and how your plan works. All the conditions and provisions of the **Contract** apply to you and your eligible dependents covered under this plan.

What is Included

The **Contract** describes how to use your plan, what services are covered, the portion of the health care cost we pay, and the portion of the health care costs you will be required to pay.

This **Contract** takes the place of all policies **Aetna** may have provided to you earlier that describe this kind of insurance.

How to Use This Document

You should read this **Contract** carefully. You are responsible for understanding the terms and conditions in this **Contract**. This **Contract** also includes the *Schedule of Benefits*, amendments, and riders.

This **Contract** contains exclusions and limitations. Please be sure to read the *Medical* and *Prescription Benefit Exclusions* sections carefully.

Common Terms

The Definition section at the back of this document defines many terms used in this **Contract**. Defined terms appear in bolded print. Knowing these terms will

- Help you know how your plan works
- Give you useful information about your plan.

How to Contact Us

We are available to answer questions you may have related to your coverage or benefits. Please see the *Contact Us* section of the **Contract** for a listing of Our website, mailing address and telephone number.

INDIVIDUAL ADVANTAGE CONTRACT COVER SHEET

[[Contract Holder or Parent/Guardian of:	**[*First Name, Middle Initial, Last Name*]**
Contract Number:	[*Member ID*]
Coverage Type]:	[*Type of Coverage*]
Effective Date:]	[*Effective Date*]
[Term of **Contract**:	The initial term shall be: From [ ] to [ ] Thereafter, subsequent terms shall be: From [ ] to [ ]]
[Premium Payment:]	*[$ Initial Premium] [$ Monthly]*
Premium Due Date:	*[1st or the 15th of each month based on your Effective Date]]]*

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna** at:

Aetna
Attn: Enrollment
P.O. Box 730
Blue Bell, PA 19422
Telephone Number: [xxx-xxx-xxxx]

You may also visit **Aetna**'s web site at www.aetna.com or contact Member Services at the toll-free telephone number on your ID card.

[AETNA HEALTH INC.]
(MAINE)

INDIVIDUAL ADVANTAGE CONTRACT

This is an Individual Advantage **Contract** (hereinafter referred to as "**Contract"** between [Aetna Health Inc.], hereinafter referred to as **Aetna,** and the **Contract Holder**. Th**is Contract** determines the terms and conditions of coverage. The **Contract** describes covered health care benefits. Provisions of this **Contract** include the Enrollment Form, *Schedule of Benefits*, and any amendments, endorsements, inserts, or attachments. Amendments, endorsements, inserts, or attachments may be delivered with the **Contract** or added thereafter.

If any provision of this **Contract** is deemed to be invalid or illegal, such provision shall be fully severable and the remaining provisions of this **Contract** shall continue in full force and effect. In consideration of the **Premium** payments made by or on behalf of the **Contract Holder**, **Aetna** shall provide coverage for those services described in this **Contract** subject to the terms and conditions set forth in this **Contract**.

Coverage is not provided for any services received before coverage starts or after coverage ends, except as shown in the Continuation section of this **Contract**.

Certain words have specific meanings when used in this **Contract**. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this **Contract**.

This Contract is not in lieu of insurance for Workers' Compensation. This Contract is governed by applicable federal law and the laws of Maine.

READ THIS ENTIRE CONTRACT CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND AETNA. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PRECERTIFICATION BY AETNA.

NO SERVICES ARE COVERED UNDER THIS CONTRACT IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE GRACE PERIOD AND THE PREMIUMS SECTION OF THE CONTRACT.

THIS CONTRACT APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CONTRACT.

PARTICIPATING PROVIDERS, NON-PARTICIPATING PROVIDERS, INSTITUTIONS, FACILITIES OR AGENCIES ARE NEITHER AGENTS NOR EMPLOYEES OF AETNA.

NOTICE TO SUBSCRIBER

For a period of ten days from the date this Individual Advantage Contract is delivered to you, this Individual Advantage Contract may be surrendered to Aetna together with written request for cancellation of the Contract and that in such event Aetna will refund any Premium paid including any contract fees or other charges, if any, less the cost of any services paid on behalf of the Subscriber or any Covered Dependent. The Contract will be deemed void from the beginning

Important

Unless otherwise specifically provided, no Member has the right to receive the benefits of this plan for health care services or supplies furnished following termination of coverage. Benefits of this plan are available only for services or supplies furnished during the term the coverage is in effect and while the individual claiming the benefits is actually covered by the Contract. Benefits may be modified during the term of this plan as specifically provided under the terms of the Contract or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of the Contract.

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AETNA PROCEDURE

This Plan includes **network providers** that are identified generically throughout the **Contract** as **Designated Network Providers** and **Non-Designated Network Providers**. The plan pays benefits differently when services and supplies are obtained through **Designated Network Providers or Non-Designated Network Providers** under this plan.

Designated and Non-Designated Network Providers
This plan provides preferred benefit coverage and access to covered services and supplies through a network of health care providers and facilities that are unique to your plan. The network has been divided into two groups. The two groups of **Providers** are called **Designated Network Providers and Non-Designated Network Providers** in this plan. This plan is designed to lower your out-of-pocket costs when you use **Designated Network Providers**. Your cost sharing will be lowest when you use the **Designated Network Providers**. Both groups of **Providers** are identified in the printed directory and the on-line version of the directory via DocFind at www.aetna.com. Please be sure to look at the appropriate directory that applies to your plan, since different **Aetna** plans use different networks of **Providers**. Your plan includes different benefit levels based upon the type of network **Provider** that you use (designated or non-designated).

Important Note:
For purposes of this plan, some **Participating Providers** have elected *not* to participate in this plan and are considered neither **Designated** nor **Non-Designated Network Providers**. Such **Providers** will be treated as **Non-Participating Providers** under this plan.

Except for **Medical Emergencies**, services and supplies obtained from **Non-Participating Providers** are not covered under the plan.

Selecting a Participating Primary Care Physician

At the time of enrollment, each **Member** may choose to select a **Participating Primary Care Physician** (**PCP)** that is a **Designated Network Provider** from **Aetna's** Directory of **Participating Providers** to access **Covered Benefits** as described in this **Contract**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf.

The Primary Care Physician

The **PCP** coordinates a **Member's** medical care, as appropriate, either by providing treatment or may direct the **Member** to other **Designated** or **Non-Designated Network Providers**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization.

The **PCP** provides services for the treatment of routine illnesses, injuries, well baby and preventive care services which do not require the services of a **Specialist**, and for non-office hour **Urgent Care** services under this plan. The **Member's** selected **PCP** or that **PCP's** covering **Physician** is required to be available 7 days a week, 24 hours a day for **Urgent Care** services.

A **Member** will be subject to the **PCP Copayment** listed on the *Schedule of Benefits* when a **Member** obtains **Covered Benefits** from any **Participating PCP**.

A **Member** who selects a **PCP** will be subject to the **PCP Copayment** listed on the *Schedule of Benefits* when a **Member** obtains **Covered Benefits** from their selected **PCP**. A **Member** may obtain **Covered Benefits** from other **Participating PCPs**. However, a **Member** will be subject to the **Specialist Copayment** listed on the *Schedule of Benefits* when a **Member** accesses a **PCP** other than their selected **PCP**. A **Member** who does not select a **PCP** will be subject to the **Specialist Copayment** listed on the *Schedule of Benefits* when a **Member** obtains **Covered Benefits** from any **Participating PCP** or **Participating Specialist**.

Certain **PCP** offices are affiliated with integrated delivery systems or other provider groups (i.e., Independent Practice Associations and Physician-Hospital Organizations), and **Members** who select these **PCPs** will generally be referred to **Specialists** and **Hospitals** within that system or group. However, if the group does not include a **Provider** qualified to meet the **Member's** medical needs, the **Member** may request to have services provided by nonaffiliated **Providers**.

Covered Benefits also include **E-visits** and **Telemedicine** consultations**.** Registration with an internet service vendor may be required**.** Information about **Participating Providers** who conduct **E-visits** and **Telemedicine** consultations may be found in the **Provider** directory, online in DocFind on www.Aetna.com or by calling the number on your **Member** identification card.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular **Provider**. Either **Aetna** or any **Participating Provider** may terminate the **Provider** contract or limit the number of **Members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, the **Member** will be notified and given an opportunity to make another **PCP** selection. The **Member** must then cooperate with **Aetna** to select another **PCP**. Until a **PCP** is selected, benefits are limited to coverage for **Medical Emergency** care.

Changing a PCP

You may change your **PCP** at any time by calling the Member Services toll-free telephone number listed on the **Member's** identification card or by written or electronic submission of the **Aetna's** change form. A **Member** may contact **Aetna** to request a change form or for assistance in completing that form. The change will become effective upon **Aetna**'s receipt and approval of the request.

Ongoing Reviews

Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **Contract**. If **Aetna** determines that the recommended services and supplies are not **Covered Benefits**, the **Member** will be notified. If a **Member** wishes to appeal such determination, the **Member** may then contact **Aetna** to seek a review of the determination. Please refer to the **Claim Procedures/Complaints and Appeals/Dispute Resolution** section of this **Contract**.

Precertification

Certain services and supplies under this **Contract** may require precertification by **Aetna** to determine if

they are **Covered Benefits** under this **Contract.**

Continuity of Care

Existing Enrollees

The following applies when your **Hospital** or **Physician**:

- Stops participation with **Aetna** as a **Participating Provider** for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the heath professional's ability to practice;

Aetna will continue coverage for an ongoing course of treatment with your current **Hospital** or **Physician** during a transitional period. Coverage shall continue for up to 90 days from the date of notice to you from **Aetna** that the provider terminated participation with **Aetna** as a **Participating Provider.**

If you have entered the second trimester of pregnancy, the transitional period will include the time required for postpartum care directly related to the delivery.

The coverage will be authorized by **Aetna** for the transitional period only if the **Hospital** or **Physician** agrees:

- To accept reimbursement at the **Negotiated Charge** and cost sharing applicable prior to the start of the transitional period as payment in full;
- To adhere to quality standards and to provide medical information related to such care; and
- To adhere to **Aetna's Contract** and procedures.

This provision shall not be construed to require **Aetna** to provide coverage for benefits not otherwise covered under this **Contract**.

With regards to the continuity of coverage provisions described above, the notice of the event provided to you by **Aetna** will include specific instructions on how to request continuity of coverage during the transitional period.

New Enrollees

If your current **Hospital** or **Physician** does *not* have a contract with **Aetna**, new enrollees may continue an ongoing course of treatment with their current **Hospital** or **Physician** for a transitional period of up to 60 days from the effective date of enrollment. If you have entered the second trimester of pregnancy as of the effective date of enrollment, the transitional period shall include the period of time that postpartum care directly related to the delivery is provided. You need to complete a *Transition of Coverage Request* form and send it to **Aetna**. Contact Member Services at the number on the back of your ID card for a copy of this form. If authorized by **Aetna**, coverage will be provided for the transitional period but only if the **Hospital** or **Physician** agrees to:

- Accept reimbursement at the **Negotiated Charge** and cost-sharing established by **Aetna** prior to the start of the transitional period as payment in full;
- Adhere to quality standards and to provide medical information related to such care; and

- Adhere to **Aetna's Contract** and procedures.

This provision shall not be construed to require **Aetna** to provide coverage for benefits not otherwise covered under this **Contract**.

ELIGIBILITY AND ENROLLMENT

Who is Eligible to be Covered

Throughout this section you will find information on who can be covered under this Policy, and what to do when there is a change in your life that affects coverage.

The Policyholder is:

- A legal resident of the State of Maine;
- age 19 and over;
- Not eligible for or enrolled in Medicare at the time of application;
- Listed as the applicant on the application;
- Approved by **Aetna;**
- Not covered by any other group or individual health plan.

Covered dependents are the following members of the Policyholder's family who are eligible, are legal residents of the state in which the Policy was issued and have been approved by **Aetna**:

- Your spouse.
- Your domestic partner. A domestic partner under this Policy is a person who certifies the following:
  - He or she is recognized as a domestic partner in accordance with applicable Maine law; and
  - He or she is not in the relationship solely for the purpose of obtaining health insurance coverage; and
  - He or she is not married or legally separated from anyone else; and
  - He or she has not registered as a member of another domestic partnership within the past six months; and
  - He or she can demonstrate interdependence with you through at least three of the following:
    - Common ownership or lease of real property (joint deed, mortgage or lease agreement);
    - Driver's license listing a common address;
    - Utility bills listing both names;
    - Proof of joint bank accounts or credit accounts;
    - Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under your will; or
    - Assignment of a durable property power of attorney or health care power of attorney.
- Your or your covered spouse's, or your covered domestic partner's children who are under 26 years of age.

Eligible dependent children include:

- Your biological children;
- Your stepchildren;
- Your legally adopted children, or children placed with you for adoption;
- Any children for whom you are responsible under court order.

Note: If the Member is covered as a dependent child, and Aetna is requested by a parent of the Member, the Aetha shall provide that parent with:

- An explanation of the payment or denial of any claim filed on behalf of the child, except to the extent that Aetna has the right to withhold consent and does not affirmatively consent to notifying the parent;
- An explanation of any proposed change in the terms and conditions of the Plan; or
- Reasonable notice that the Plan may lapse, but only if you have provided Aetna with the address at which you may be notified.

In addition, any parent who is able to provide the information necessary for Aetna to process a claim must be permitted to authorize the filing of any claims under the Plan.

Special Circumstances:

- Newborns of the Policyholder, covered spouse or covered domestic partner are automatically covered for the first 31 days of life. TO CONTINUE COVERAGE, THE NEWBORN MUST BE ENROLLED AS A DEPENDENT BY NOTIFYING **AETNA** IN WRITING WITHIN 31 DAYS OF BIRTH. THE POLICYHOLDER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUM CHARGES DUE EFFECTIVE FROM THE DATE OF BIRTH.
- A child being adopted by the Policyholder or covered domestic partner will have coverage for the first 31 days from the date on which the adoptive child's birth parent or appropriate legal authority signs a written document granting the Policyholder or covered domestic partner the right to control health care for the adoptive child, or absent this document, the date on which other evidence exists of this right. TO CONTINUE COVERAGE, THE ADOPTED CHILD MUST BE ENROLLED AS A FAMILY MEMBER BY NOTIFYING US IN WRITING WITHIN 31 DAYS OF THE DATE THE POLICYHOLDER'S OR COVERED DOMESTIC PARTNER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED. THE POLICYHOLDER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUM CHARGES DUE EFFECTIVE FROM THE DATE THE POLICYHOLDER'S OR COVERED DOMESTIC PARTNER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED.
- Newborns who are the children of a Policyholder's covered dependent under this policy are not covered after the first 31 days under this policy unless the Policyholder or the Policyholder's covered spouse or covered domestic partner has obtained court ordered custody of the child.
- Coverage for handicapped dependent children may continue after your dependent child reaches the limiting age. See *When Coverage Ends* for more information.

Effective Date of Coverage for Dependents

Coverage for your dependents will take effect on the first of the month after approved by **Aetna** and consistent with your Premium Due Date (as shown on your *Insert A*).

Notice of Change in Eligibility

You must notify **Aetna** of all changes affecting your or any covered dependent's eligibility under this Policy within 31 days of the change.

Failure to notify **Aetna** of the change within the designated 31 day timeframe may result in **Aetna**'s denying the request for a retroactive eligibility date.

How And When To Enroll
Initial Enrollment In The Plan

You will be provided with plan benefit and enrollment information when you first decide to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions, if any, for any contributory coverage.

Special Enrollment Periods

Aetna may offer general enrollment periods in your state. If so, and you do not enroll during this time period, you may be considered a late enrollee and may not be able to enter the plan unless you qualify under a *Special Enrollment Period* as described below. If one of these situations applies, you may be able to enroll before the next general enrollment period.

Loss of Other Health Care Coverage

These are some of the reasons that you or your dependents may qualify for a *Special Enrollment Period*:

- You did not enroll yourself or your dependent during a general enrollment period because, at that time:
  - You or your dependents were covered under other another plan; and
- You or your dependents are no longer eligible for the other plan because of one of the following:
  - The end of your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Death;
  - Divorce or legal separation;
  - Employer contributions toward that coverage have ended;
  - COBRA coverage ends;
  - The employer's decision to stop offering a group health plan to the eligible class to which you belong;
  - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
  - With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; or
  - You or your dependents have reached the lifetime maximum of another plan for all benefits under that plan.

Please contact **Aetna** at www.aetna.com for detailed information regarding Special Enrollment Periods.

COVERED BENEFITS

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **Contract**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **Aetna** may determine whether any benefit provided under the **Contract** is **Medically Necessary**, and **Aetna** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Preventive care, as described below, will be considered **Medically Necessary**.

Important Note:
You should review your *Schedule of Benefits* for the cost sharing that applies to the **Covered Benefits** in this section. This will help you become familiar with your payment responsibilities.

Some **Covered Benefits** may have visit limits and maximums that apply to the service or supply. You should always review your **Contract** and *Schedule of Benefits* together.

ALL SERVICES ARE SUBJECT TO THE EXCLUSIONS AND LIMITATIONS DESCRIBED IN THIS CONTRACT.

To be **Medically Necessary**, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;

- Be care or services related to diagnosis or treatment of an existing illness or injury, except for Preventive Care Benefits, as determined by **Aetna**;

- Be a diagnostic procedure, indicated by the health status of the **Member** and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;

- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a **Physician's** office, on an outpatient basis, or in any facility other than a **Hospital**, when used in relation to inpatient **Hospital** services; and

- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is **Medically Necessary**, **Aetna's** Patient Management Medical Director or its **Physician** designee will consider:

- Information provided on the **Member's** health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;

- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of **Health Professionals** in the generally recognized health specialty involved;
- The opinion of the attending **Physicians**, which have credence but do not overrule contrary opinions; and
- Any other relevant information brought to **Aetna**'s attention.

All **Covered Benefits** will be covered in accordance with the guidelines determined by **Aetna**.

If a **Member** has questions regarding coverage under this **Contract**, the **Member** may call the Member Services toll-free telephone number listed on the **Member's** identification card.

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF ANY APPLICABLE COPAYMENTS AND DEDUCTIBLES LISTED ON THE *SCHEDULE OF BENEFITS*.

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY OR URGENT CARE SITUATION AS DESCRIBED IN THIS CONTRACT, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP'S OFFICE THAT IS SHOWN ON THE MEMBER'S IDENTIFICATION CARD.

1. Preventive Care and Wellness Benefits

Preventive Care

1. The recommendations and guidelines of the:

   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
   - United States Preventive Services Task Force;
   - Health Resources and Services Administration; and
   - American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents

   as referenced throughout this Preventive Care Benefit may be updated periodically. This Plan is subject to updated recommendations or guidelines that are issued by these organizations beginning on the first day of the plan year, one year after the recommendation or guideline is issued.

2. If any *diagnostic* x-rays, lab, or other tests or procedures are ordered, or given, in connection with any of the Preventive Care Benefits described below in situations where the patient is exhibiting symptoms, those diagnostic x-rays, lab or other tests or procedures will not be covered as Preventive Care Benefits. Those that are **Covered Benefits** will be subject to the cost-sharing that applies to those specific services under this Plan.

3. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to the Aetna Navigator® secure member website at www. aetna.com] or calling the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

Routine Physical Exam Benefit

Covered Benefits include office visits to a **Member's Primary Care Physician (PCP)** for routine physical exams, including routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a **PCP** for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:

    - Screening and counseling services, such as those on:
        - Interpersonal and domestic violence;
        - Sexually transmitted diseases; and
        - Human Immune Deficiency Virus (HIV) infections.
    - Screening for gestational diabetes.
    - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial **Hospital** checkup.

    Benefits for the routine physical exam services above may be subject to visit maximums as shown in the *Schedule of Benefits.*

    For details on the frequency and age limits that apply to Routine Physical Exam Benefit, **Members** may contact their **Physician** or **Member Services** by logging onto the Aetna Navigator website www.aetna.com, or calling the toll-free number on the back of the ID card.

Benefit Limitations:
Unless specified above, not covered under this benefit are:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given while the **Member** is confined in a H**ospital** or other facility for medical care;
- Services not given by a **Physician** or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams.

Preventive Care Immunizations Benefit

Covered Benefits include:

- Immunizations for infectious diseases; and
- The materials for administration of immunizations;

provided by a **Member's PCP** or a facility. The immunizations must be recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Benefit Limitations:

Not covered under this benefit are:

- Services which are covered to any extent under any other part of this plan; and
- Immunizations that are not considered preventive care such as those required due to a **Member's** employment or travel.

Preventive Care Drugs and Supplements

Covered expenses include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a **pharmacy**. They are covered when they are:

- prescribed by a **physician**;
- obtained at a **pharmacy;** and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this Plan include, but may not be limited to:

- *Aspirin:* Benefits are available to adults.
- *Oral Fluoride Supplements:* Benefits are available to pre-school children whose primary water source is deficient in fluoride.
- *Folic Acid Supplements:* Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- *Iron Supplements:* Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
- *Vitamin D Supplements:* Benefits are available to adults to promote calcium absorption and bone growth in their bodies.

Risk Reducing Breast Cancer Prescription Drugs

Covered expenses include **prescription drugs** when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing for a woman who is at:

- Increased risk for breast cancer, and
- Low risk for adverse medication side effects

Coverage of preventive care drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.

Important Note:
For details on the guidelines and the current list of covered preventive care drugs and supplements, including risk reducing breast cancer **prescription drugs**, contact Member Services by logging on to your Aetna Navigator® secure member website at www. Aetna.com or at the toll-free number on your ID card.

Refer to the *Schedule of Benefits* for the cost-sharing and supply limits that apply to these benefits.

Reimbursement of Preventive Care Drugs and Supplements at a Pharmacy

You will be reimbursed by **Aetna** for the cost of the preventive care drugs and supplements when you submit proof of loss to **Aetna** that you purchased a preventive care drug or supplement at **a pharmacy**.

"Proof of loss" means a copy of the receipt that contains the **prescription** information provided by the **pharmacist** (it is attached to the bag that contains the preventive care OTC drug or supplement).

Refer to the provisions *Proof of Loss and Claims Payment* later in this contract for information. You can also contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Well Woman Preventive Visits Benefit

- **Covered Benefits** include a routine well woman preventive exam office visit, including Pap smears, provided by a **Member's PCP, Physician,** obstetrician, or gynecologist. A routine well woman preventive exam is a medical exam given by a **Physician** for a reason other than to diagnose or treat a suspected or identified illness or injury; and
- **[**routine] preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. **Covered Benefits** include charges made by a **Physician** and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

These benefits will be subject to any age; family history; and frequency guidelines that are:

Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and

- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Benefits for the well woman preventive visit services above are subject to visit maximums as shown in the *Schedule of Benefits***.**

Benefit Limitations:
Unless specified above, not covered under this benefit are:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given while the **Member** is confined in a H**ospital** or other facility for medical care;
- Services not given by a **Physician** or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams.

Screening and Counseling Services Benefit

Covered Benefits include the following services provided by a **Member's PCP** or **Physician,** as applicable**,** in an individual or group setting:

Obesity and Healthy Diet Counseling Benefit

Covered Benefits include screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention;
- Nutritional counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Misuse of Alcohol and/or Drugs Benefit

Covered Benefits include screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Use of Tobacco Products Benefit

Covered Benefits include screening and counseling services to aid in the cessation of the use of tobacco products.

Coverage includes:

- Coverage of nicotine replacement therapy products and any other **prescription drugs** and medication specifically approved by the FDA for smoking cessation, including but not limited to, nicotine patches, gum or nasal spray.
- Preventive counseling visits;
- Treatment visits; and
- Class visits;

to aid in the cessation of the use of tobacco products.

Tobacco product means a substance containing tobacco or nicotine including:

- Cigarettes;
- Cigars;
- Smoking tobacco;
- Snuff;
- Smokeless tobacco; and
- Candy-like products that contain tobacco.

Sexually Transmitted Infection Counseling

Covered Benefits include the counseling services to help you prevent or reduce sexually transmitted infections.

Genetic Risk Counseling for Breast and Ovarian Cancer

Covered Benefits include the counseling and evaluation services to help you assess whether or not you are at risk of breast and ovarian cancer.

Benefits for the screening and counseling services above are subject to any visit maximums as shown in the *Schedule of Benefits***.**

Benefit Limitations:
Unless specified above, not covered under this benefit are services which are covered to any extent under any other part of this **Contract**.

Routine Cancer Screenings Benefit

Covered Benefits include, but are not limited to, the following routine cancer screenings:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enema (DCBE); and
- Colonoscopies; (including the removal of polyps performed during a screening procedure); and
- Lung cancer screenings.

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

For details on the frequency and age limits that apply to Routine Cancer Screenings Benefit, **Members** may contact their **Physician** or **Member Services** by logging onto the Aetna Navigator website www.aetna.com, or calling the toll-free number on the back of the ID card.

As to routine gynecological exams performed as part of a routine cancer screening, the **Member** may go directly to a **Participating** obstetrician (OB), gynecologist (GYN)**, o**bstetrician/gynecologist (OB/GYN)**.** See the **Direct Access Specialist Benefits** section of the **Contract**, for a description of this provision.

Benefit Limitations:

Unless specified above, not covered under this benefit are services which are covered to any extent under any other part of this Plan.

Prenatal Care Benefit

Covered Benefits include prenatal care services received by a pregnant female in a **PCP, Physician's**, OB/GYN, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this benefit is limited to pregnancy-related **Physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height).

Benefit Limitations:

Unless specified above, not covered under this benefit are:

- Services which are covered to any extent under any other part of this Plan; and
- Services for maternity care (other than prenatal care as described above).

Important Note:

Refer to the:

- *Maternity Care and Related Newborn Care Benefits* section of the **Contract**; and
- **Prenatal Care Services, Delivery Services and Postpartum Care Services** cost-sharing in the *Schedule of Benefits***;**

for more information on coverage for services related to maternity care under this Plan.

Comprehensive Lactation Support and Counseling Services Benefit

Covered Benefits include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy or at any time following delivery, for breast-feeding by a certified lactation support provider. **Covered Benefits** also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **Covered Benefits** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown later in this amendment**.**

Breast Feeding Durable Medical Equipment

Covered Benefits includes the rental or purchase of breast feeding **Durable Medical Equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows (there is no cost-sharing for these services).

Breast Pumps

Covered Benefits include the following:

- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **Hospital**.
- The purchase of:
  - An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or
  - A manual breast pump. A purchase will be covered once per pregnancy.

- If a breast pump is purchased within the previous one year period, the purchase of another breast pump will not be covered until a one year period has elapsed from the last purchase.

Breast Pump Supplies

Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. A **Member** is responsible for the entire cost of any additional pieces of the same or similar equipment purchased or rented for personal convenience or mobility.

Aetna reserves the right to limit **Covered Benefits** to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

Benefit Limitations:

Unless specified above, not covered under this benefit are services which are covered to any extent under any other part of this Plan.

[Family Planning Services - Female Contraceptives Benefit

For females with reproductive capacity, **Covered Benefits** include those services and supplies that are provided to a **Member** to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **PCP, Physician,** OB/GYN, obstetrician or gynecologist. Such counseling services are **Covered Benefits** when provided in either a group or individual setting. They are subject to the contraceptive counseling services visit maximum as shown later in this amendment**.**

The following contraceptive methods are **Covered Benefits** under this benefit:

Voluntary Sterilization

Covered Benefits include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered Benefits under this benefit would not include a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of the confinement.

Contraceptives

Covered expenses include charges made by a **physician** or **pharmacy** for:

- Services and supplies needed to administer or remove a covered contraceptive **prescription drug** or device;
- Female oral and injectable contraceptive that are **biosimilar prescription drugs, brand name prescription drugs** and **generic prescription drugs**;
- Female contraceptive devices that are generic devices and brand name devices;
- FDA-approved female:
    - Biosimilar, brand name and generic emergency contraceptives;
    - Brand name and generic over-the-counter (OTC) emergency contraceptives for which a **prescription** is not needed.

Coverage is limited to 1 emergency contraceptive(s) per month.

- FDA-approved female brand name and generic over-the-counter (OTC) contraceptives. Coverage is limited to one per day and a 30 day supply per **prescription**.

FDA-approved male brand name and generic over-the-counter (OTC) contraceptives. Coverage is limited to one per day and a 30 day supply per **prescription**.
When contraceptive methods are obtained at a **pharmacy**, **prescriptions** must be submitted to the pharmacist for processing.

Reimbursement of Over-the-Counter (OTC) Contraceptives at a Pharmacy

The FDA-approved OTC contraceptives described above are covered under this Plan when they are:

- prescribed by a **physician**;
- obtained at a **pharmacy**; and
- submitted to a pharmacist for processing.

You will be reimbursed by **Aetna** for the cost of the OTC contraceptive when you submit proof of loss to **Aetna** that you purchased the OTC contraceptive. "Proof of loss" means a copy of the receipt that contains the **prescription** information provided by the **pharmacist** (that is attached to the bag that contains the OTC contraceptive).

Refer to the provisions *Proof of Loss and Claims Payment* later in this contract for information on submitting claims. You can also contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Important Note:
This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact your **physician** or Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Important Reminder:
Refer to the section *"Your Pharmacy Benefit"* later in this **Contract** for additional coverage of female contraceptives.

Benefit Limitations:

Unless specified above, not covered under this benefit are:

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;
- Services which are for the treatment of an identified illness or injury;
- Services that are not given by a **Physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices; and
- The reversal of voluntary sterilization procedures, including any related follow-up care.]

2. Physician and Other Health Professional Care

Primary Care Physician Benefit

Covered Benefits include:

- Office visits during office hours.
- Home visits.
- After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP's** regular office hours, the **Member** should:

  - call the **PCP's** office;
  - identify himself or herself as a **Member**; and
  - follow the **PCP's** or covering **Physician's** instructions.

  If the **Member's** injury or illness is a **Medical Emergency**, the **Member** should follow the procedures outlined under the Emergency Care/**Urgent Care** Benefits section of this **Contract**.

- **Hospital** visits.
- Immunizations for infectious disease, but not if solely for your employment or travel.
- Allergy testing and allergy injections.
- Charges made by the **Physician** for supplies, radiological services, x-rays, and tests provided by the **Physician**.

Covered Benefits also include:

- Outpatient services rendered in certified rural health clinics.

Alternatives to Physicians' Office Visits

Walk-in Clinic Benefits

Covered Benefits include charges made by **walk-in clinics** for:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid you:
  - In weight reduction due to obesity;
  - In developing and maintaining a healthy diet;
  - To stop the use of tobacco products;
  - In stress management.

  The stress management counseling sessions will:
  - Help you to identify the life events which cause you stress (the physical and mental strain on your body.); and
  - Teach you techniques and changes in behavior to reduce the stress.

Benefit Limitations:
Unless specified above, not covered under this benefit are charges incurred for services and supplies furnished in a group setting for screening and counseling services

Important Note:

- Not all services are available at all Walk-In Clinics. The types of services offered will vary by the provider and location of the clinic.
- For a complete description of the screening and counseling services provided on the use of tobacco products and to aid in weight reduction due to obesity, refer to the *Preventive Care Benefits* section in this **Contract** and the *Screening and Counseling Services* benefit for a description of these services.
- These services may also be obtained from your **PCP**.

E-Visits and Telemedicine Consultation

Covered Benefits include charges made by your **PCP** for a routine, non-emergency, medical consultation. You must make your **E-visit** or **Telemedicine** consultation appointment through an **Aetna** authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.aetna.com or by calling the number on your identification card.

Specialist Physician Benefits

Covered Benefits include outpatient and inpatient services.

Covered Benefits also include **E-visits.** Registration with an internet service vendor may be required**.** Information about **Participating Providers** who conduct **E-visits** may be found in the provider Directory, online in DocFind on www.Aetna.com or by calling the number on your **Member** identification card.

Important Reminder:
For a description of the preventive care benefits covered under this **Contract**, refer to the *Preventive Care Benefits* section in this **Contract**.

3. Hospital and Other Facility Care

Hospital Benefit

Covered Benefits include services provided during a person's inpatient **Hospital** stays (including coverage for anesthesia and related charges for dental procedures rendered in the **Hospital** where the clinical status of the person or underlying medical condition requires the procedure to be rendered in the **Hospital**.) A **Member** is covered for services only at **Participating Hospitals**. All services are subject to precertification by **Aetna**. In the event that the **Member** elects to remain in the **Hospital** after the date that the **Participating Provider** and/or the **Aetna** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Hospital** Facility for such additional **Hospital, Physician** and other **Provider** services, and **Aetna** shall not be financially responsible for such additional services.

Covered Benefits include general anesthesia and associated facility charges apply to the following:

a. You and your dependents, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;
b. You and your dependents that demonstrate dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
c. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and
d. You and your dependents who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

Inpatient **Hospital** cardiac and pulmonary rehabilitation services are covered by **Participating Providers** and precertification by **Aetna**.

Skilled Nursing Facility Benefit

Covered Benefits include stays in a **Skilled Nursing Facility**. A **Member** is covered for services only at **Participating Skilled Nursing Facilities**. All services are subject to precertification by **Aetna**. In the event that the **Member** elects to remain in the **Skilled Nursing Facility** after the date that the **Participating Provider** and/or the **Aetna** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Skilled Nursing Facility** for such additional **Skilled Nursing Facility, Physician** and other **Provider** services, and **Aetna** shall not be financially responsible for such additional services.

Outpatient Surgery Benefit

Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by a **Participating** outpatient surgery center. All services and supplies are subject to precertification by **Aetna**.

Home Health Benefit

Covered Benefits include the following services for a **Homebound Member** when provided by a **Participating** home health care agency. **Precertification** must be obtained from the **Aetna** by the **Member's** attending **Participating Physician**. **Aetna** shall not be required to provide home health benefits when **Aetna** determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide covered health care services. Coverage for **Home Health Services** is not determined by the availability of caregivers to perform the services; the absence of a person to perform a non-skilled or **Custodial Care** service does not cause the service to become covered. If the **Member** is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for **Home Health Services** will only be provided during times when there is a family member or caregiver present in the home to meet the **Member's** non-skilled needs.

Skilled Nursing services that require the medical training of and are provided by a licensed nursing professional are a covered benefit. Services must be provided during intermittent visits of 4 hours or less with a daily maximum of 3 visits. Up to 12 hours (3 visits) of continuous **Skilled Nursing** services per day within 30 days of an inpatient **Hospital** or **Skilled Nursing Facility** discharge may be covered, when all home health care criteria are met, for transition from the **Hospital** or **Skilled Nursing Facility** to home care.

Services of a home health aide are covered only when they are provided in conjunction with **Skilled Nursing** services and directly support the **Skilled Nursing.** Services must be provided during intermittent visits of 4 hours or less with a daily maximum of 3 visits.

Medical social services are covered only when they are provided in conjunction with **Skilled Nursing** services and must be provided by a qualified social worker.

Outpatient home health short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Coverage is subject to the conditions and limits listed in the Short-Term Rehabilitation Therapy Services Benefit section of the **Certificate** and the Short-Term Rehabilitation and Habilitation Therapy Services Benefit section of the Schedule of Benefits

Covered **Home Health Care** benefits do not include charges for infusion therapy.

Hospice Benefit

Covered Benefits include **Hospice Care** services provided for a terminally ill **Member** are covered when precertified by **Aetna**. Services include, but are not limited, to home and **Hospital** visits by physicians, nurses and social workers, occupational and physical care; medical supplies and durable medical equipment, pain management and symptom control; instruction and supervision of a family **Member**; inpatient care; respite care; counseling and emotional support; nutritional counseling; and other home health benefits listed in the Home Health Benefits section of this **Contract**.

Coverage is not provided for funeral arrangements, pastoral counseling, and financial or legal counseling. Homemaker or caretaker services, and any service not solely related to the care of the **Member**, including but not limited to, sitter or companion services for the **Member** or other **Members** of the family, transportation, house cleaning, and maintenance of the house are not covered.

4. Emergency Care and Urgent Care

Emergency Care/Urgent Care Benefit

1. **Emergency Care**:

   A **Member** is covered for **Emergency Services**, provided the service is a **Covered Benefit**, and **Aetna**'s review determines that a **Medical Emergency** existed at the time medical attention was sought by the **Member**.

   The **Copayment** for an emergency room visit as described on the *Schedule of Benefits* will not apply in the event that the **Member** is admitted into the **Hospital**.

   The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-participating **Provider** located either within or outside the **Aetna Service Area**, for those expenses, less **Copayments**, which are incurred up to the time the **Member** is determined by **Aetna** and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**. In the event that transportation is required, the **Member** will be reimbursed for the cost as determined by **Aetna**, minus any applicable **Copayments**. Reimbursement may be subject to payment by the **Member** of all **Copayments** which would have been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

   Medical transportation is covered during a **Medical Emergency**.

2. **Urgent Care**:

   Urgent Care Within the Aetna Service Area. If the **Member** needs **Urgent Care** while within the **Aetna Service Area**, but the **Member's** illness, injury or condition is not serious enough to be a **Medical Emergency**, the **Member** should first seek care through the **Member's PCP.** If the **Member's PCP** is not reasonably available to provide services for the **Member**, the **Member** may access **Urgent Care** from a **Participating Urgent Care Facility** within the **Aetna Service Area**.

   Urgent Care Outside the Aetna Service Area. The **Member** will be covered for **Urgent Care** obtained from a **Physician** or licensed facility outside of the **Aetna Service Area** if the **Member** is temporarily absent from the **Aetna Service Area** and receipt of the health care service cannot be delayed until the **Member** returns to the **Aetna Service Area**.

   A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for **Emergency Services** which is provided to a **Member** after the **Medical Emergency** or **Urgent Care** situation has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all services received.

5. Specific Conditions

Maternity Care and Related Newborn Care Benefit

Covered Benefits include outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers**. The **Participating Provider** is responsible for obtaining any required precertification for all non-routine obstetrical services from **Aetna** after the first prenatal visit.

Coverage does not include routine maternity care (including delivery) received while outside the **Service Area** unless the **Member** receives **precertification** from **Aetna**.

As an exception to the **Medically Necessary** requirements of this **Contract**, the following coverage is provided for a mother and newly born child:

- A minimum of 48 hours of inpatient care in a **Participating Hospital** following a vaginal delivery;

- A minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section; or

- A shorter **Hospital** stay, if requested by a mother, and if determined to be medically appropriate by the **Participating Providers** in consultation with the mother.

Reconstructive Breast Surgery Benefit

Covered Benefits include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is **surgery** on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Reconstructive or Cosmetic Surgery and Supplies

Covered Benefits include charges made by a **Physician**, **Hospital**, or surgery center for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

Important Note: Injuries that occur as a result of a medical (*i.e.*, non surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when
  - The defect results in severe facial disfigurement, or
  - The defect results in significant functional impairment and the surgery is needed to improve function.

Breast Reduction Surgery Benefit and Symptomatic Varicose Vein Surgery

Covered Benefits include medically necessary breast reduction surgery and symptomatic varicose vein surgery for a covered person, when determined to be medically necessary.

Mental Disorders Benefit

Covered Benefits include charges incurred for the treatment of **Mental Disorders** by **Behavioral Health Providers**.

Important Reminder
Not all types of services are covered. For example, certain types of therapies are not covered. See *Exclusions* section for more information.

Covered Benefits include charges made by a **Hospital**, **Psychiatric Hospital**, **Residential Treatment Facility** or **Behavioral Health Provider** for the treatment of **Mental Disorders** as follows:

- Inpatient room and board at the semi-private room rate**,** and other services and supplies related to your condition that are provided during your stay in a **Hospital**, **Psychiatric Hospital**, or **Residential Treatment Facility**. Inpatient benefits are payable only if the severity of your condition requires services that are only available in an inpatient setting.

- Outpatient treatment received while not confined as an inpatient in a **Hospital** or **Psychiatric Hospital** or as part of **Partial Hospitalization Treatment** as described below.

  Partial Hospitalization Treatment (more than 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program for short-term and intensive treatment provided under the direction of a **Physician**. The facility or program does not make a room and board charge for the treatment. **Partial Hospitalization Treatment** will only be covered if:
  - You would need a higher level of care (for example, inpatient, residential, crisis stabilization) if you were not admitted to this type of facility or program; and
  - The severity of your condition requires services provided in a **Partial Hospitalization Treatment** setting.

Benefits are payable in the same way as those for any other disease.

Important Reminder
Inpatient and certain outpatient treatments must be precertified by **Aetna.**

Substance Abuse Benefit

Covered Benefits include charges incurred for the treatment of **Substance Abuse** by **Behavioral Health Providers** and medical addictionologists. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

There is a written treatment plan supervised by a **Physician** or licensed provider;

Important Note:
Not all types of services are covered. For example, certain types of therapies are not covered. See *Exclusions* section for more information.

Covered Benefits include charges made by a **Hospital**, **Psychiatric Hospital**, **Residential Treatment Facility** or **Behavioral Health Provider** for the treatment of **Substance Abuse** as follows:

- Inpatient room and board at the semi-private room rate and other services and supplies that are provided during your stay in a **Hospital**, **Psychiatric Hospital** or **Residential Treatment Facility.** Inpatient benefits are payable only if the severity of your condition requires services that are only available in an inpatient setting. Treatment in a **Hospital** is covered only when the **Hospital** does not have a separate **Substance Abuse** section or unit, or is for treatment of medical complications of **Substance Abuse**.

  As used here, "medical complications" include, but are not limited to, **Detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a **Hospital or Psychiatric Hospital** or as part of **Partial Hospitalization Treatment** as described below.

  Partial Hospitalization Treatment (more than 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program for short-term and intensive treatment provided under the direction of a **Physician**. The facility or program does not make a **room and board** charge for the treatment. **Partial Hospitalization Treatment** will only be covered if:
  - You would need a higher level of care (for example, inpatient, residential, crisis stabilization) if you were not admitted to this type of facility or program; and
  - The severity of your condition requires services provided in a **Partial Hospitalization Treatment** setting.

Benefits are payable in the same way as those for any other disease.

Important Reminder
Inpatient and certain outpatient treatments must be precertification by **Aetna.**

Autism Spectrum Disorders Benefit

Covered Benefits include the services and supplies for the diagnosis and treatment, (including behavioral therapy and Applied Behavioral Analysis), of **Autism Spectrum Disorder** when ordered by a **Physician** as part of a Treatment Plan and

The covered expenses are incurred for covered children who are 10years of age or under.

Applied Behavioral Analysis is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder--Not Otherwise Specified.

Important: Applied Behavioral Analysis requires pre-certification by Aetna and the Participating Provider is responsible for obtaining pre-certification.

Diabetes Benefit

Covered Benefits include charges for the following services, supplies, equipment, and training for the treatment of insulin- and non-insulin-dependent diabetes and elevated blood glucose levels during pregnancy:

- **Services and Supplies:**
  - Foot care to minimize the risk of infection;
  - Insulin preparations;
  - Diabetic needles and syringes;
  - Injection aids for the blind;
  - Diabetic test agents;
  - Lancets/lancing devices;
  - Prescribed oral medications whose primary purpose is to influence blood sugar;
  - Alcohol swabs;
  - Injectable glucagons; and
  - Glucagon emergency kits.

- **Equipment:**
  - External insulin pumps; and

- Blood glucose monitors without special features unless required due to blindness.

- **Training:**
  - Self-management training provided by a licensed health care provider certified in diabetes self-management training.

Treatment of Basic Infertility Services Benefit

Covered Benefits include only those **Infertility** services provided to a **Member**: a) by a **Participating Provider** to diagnose **Infertility**; and b) by a **Participating Infertility Specialist** to surgically treat the underlying cause of **Infertility**.

Transplant Benefit

Once it has been determined that a **Member** may require a **Transplant**, the **Member** or the **Member's Physician** must call the **Aetna** precertification department to discuss coordination of the **Transplant** process. **Covered Benefits** include non-experimental or non-investigational **Transplants** coordinated by **Aetna** and performed at an **Institute of Excellence, (IOE**. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the **Transplant** required by the **Member**.

Covered Benefits include the following when provided by an **IOE**.

- Inpatient and outpatient expenses directly related to a **Transplant Occurrence.**
- Charges made by a **Physician** or **Transplant** team.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your: biological parent, sibling or child.
- Charges for activating the donor search process with national registries.
- Charges made by a **Hospital** or outpatient facility and/or **Physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the **IOE** facility during the **Transplant** Occurrence process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; **Home Health Services** and home infusion services.

Any **Copayments** or **Coinsurance** associated with **Transplants** are set forth in the ***Schedule of Benefits***. **Copayments** or **Coinsurance** apply per **Transplant Occurrence**.

One **Transplant Occurrence** includes the following four phases of **Transplant** care:

- **Pre-Transplant Evaluation/Screening**: Includes all **Transplant**-related professional and technical components required for assessment, evaluation and acceptance into a **Transplant** facility's **Transplant** program.

- **Pre-Transplant/Candidacy Screening:** Includes HLA typing of immediate family members.

- **Transplant Event:** Includes inpatient and outpatient services for all **Transplant**-related health services and supplies provided to a **Member** and donor during the one or more surgical procedures or medical therapies for a **Transplant**; **Prescription Drug**s provided during the

Member's inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during the **Member's** inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.

- **Follow-up Care:** Includes **Home Health Services;** home infusion services; and **Transplant**-related outpatient services rendered within 180 days from the date of the **Transplant.**

    - Heart/Heart Valve;
    - Lung;
    - Heart/Lung;
    - Simultaneous Pancreas Kidney (SPK);
    - Adrenal glands
    - Bone and Cartilage
    - Islet Tissue
    - Parathyroid
    - Cornes
    - Muscle, Skin and Tendons
    - Blood Vessels
    - Pancreas;
    - Kidney;
    - Liver;
    - Intestine;
    - Bone Marrow/Stem Cell, including Allogeneic and Autologous Bone Marrow;
    - Multiple organs replaced during one transplant surgery;
    - Tandem transplants (Stem Cell);
    - Sequential transplants;
    - Re-transplant of same organ type within 180 days of the first transplant;
    - Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be more than one **Transplant Occurrence**:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;

- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

Benefit for Leukocite Testing to Establish Bone Marrow Donor

Covered expenses will include a benefit for human leukocyte antigen testing to establish bone marrow transplantation suitability, as established by the National Bone Marrow Donor Program. The benefit will consist of payment of the charge at 100%, up to $150 for each occurrence.

6. Specific Therapies and Tests

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Benefit

Covered Benefits include charges made on an outpatient basis by a **Physician**, **Hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medicine imaging, including Positron Emission Tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service costing over $500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Benefit Limitations:
The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Diagnostic Lab Work

Covered Benefits include charges for lab services, and pathology and other tests provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **Physician**. The charges must be made by a **Physician**, **Hospital** or licensed radiological facility or lab.

Important Reminder:
Refer to the *Schedule of Benefits* for details about any cost-sharing or benefit maximums that may apply to outpatient diagnostic testing, lab services and radiological services.

Outpatient Diagnostic Radiological Services

Covered Benefits include charges for radiological services (other than complex imaging services), provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **Physician**. The services must be provided by a **Physician**, **Hospital** or licensed radiological facility.

Benefit Limitations:
The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **Covered Benefits** include charges made for tests performed by a **Hospital**, **Physician** or licensed diagnostic laboratory provided the charges for the surgery are **Covered Benefits** and the tests are:

- Related to your surgery, and the surgery takes place in a **Hospital**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **Hospital**;
- Not repeated in or by the **Hospital** where the surgery will be performed.
- Test results should appear in your medical record kept by the **Hospital** where the surgery is performed.

Benefit Limitations:
The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will ***not*** be covered.

Important Reminder:
Complex Imaging testing for preoperative testing is covered under the *Diagnostic Complex Imaging Expense* section. Separate cost sharing may apply. Refer to your *Schedule of Benefits* for information on cost sharing amounts for complex imaging.

Clinical Trial Therapies (Experimental or Investigational Treatment Benefit)

Covered Benefits include charges made for **Experimental or Investigational** drugs, devices, treatments or procedures, during "an approved clinical trial", provided ***all*** of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- "An approved clinical trial" is a clinical trial that meets all these criteria:
    - The FDA has approved the drug, device, treatment or procedure to be investigated or granted it investigational new drug (IND) or Group c/treatment IND status;
    - The clinical trial has been approved by an Institutional Review Board that will oversee the investigation;
    - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization;
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution; and
- You are treated in accordance with the protocols of that study.

Clinical Trials (Routine Patient Costs)

Covered Benefits include "routine patient costs" furnished to you in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709. An approved clinical trial must satisfy one of the following:

- Federally funded trials:
  The study or investigation is approved or funded by one or more of the following:
  - The National Institutes of Health
  - The Department of Health and Human Services
  - The Centers for Disease Control and Prevention
  - The Agency for Health Care Research and Quality
  - The Centers for Medicare & Medicaid Services
  - Cooperative group or center of any of the entities described in the entities listed above or the Department of Health, Department of Defense or the Department of Veterans Affairs
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - The Department of Veterans Affairs
  - The Department of Defense
  - The Department of Energy
  - For those approved by the Department of Veterans Affairs, Defense or Energy, the study or investigation must have been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines:
    - To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health
    - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

Coverage is limited to benefits for routine patient services provided within the network.

Outpatient Therapies

Infusion Therapy Benefit

Covered Benefits include infusion therapy you receive in an outpatient setting. An outpatient setting includes but is not limited to:

- A free-standing outpatient facility
- The outpatient department of a **Hospital**
- A **Physician** in his/her office or in your home

You can access the list of preferred infusion locations by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.Aetna.com or calling the number on the back of your ID card.

Infusion therapy is the intravenous administration of prescribed medications or solutions.

Certain infused medications may be covered under the pharmacy benefit as **specialty Prescription Drugs**. You can access the list of these **specialty care Prescription Drugs** to determine if the drugs are covered under the pharmacy or medical benefit by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.Aetna.com or calling the number on the back of your ID card.

When infusion therapy services and supplies are provided in your home, they will not count toward any applicable **home health care** maximums.

Chemotherapy

Covered Benefits include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **Hospitalization** for chemotherapy is limited to the initial dose while **Hospitalized** for the diagnosis of cancer and when a **Hospital** stay is otherwise covered based on your health status.
This includes coverage for prescribed, orally administered anti-cancer medications used to kill or slow down the growth of cancer cells, when is equivalent to intravenous or injected anti-cancer medications.

Radiation Therapy Benefit

Covered Benefits include charges for the treatment of illness by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Short-term Rehabilitation Therapies Services Benefit

Covered Benefits include the following when rendered by **Participating Providers** upon **Referral** issued by the **Member's PCP** and **Precertified** by **Aetna.**

Cardiac and Pulmonary Rehabilitation Benefits

- Cardiac rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A course of outpatient cardiac rehabilitation appropriate for your condition is covered for a cardiac condition that can be changed.

  The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a **Physician**.

- Pulmonary rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A course of outpatient pulmonary rehabilitation appropriate for your condition is covered for the treatment of reversible pulmonary disease states.

Cognitive Therapy, Physical Therapy, Occupational Therapy, and Speech Therapy Rehabilitation Benefits

Covered Benefits include charges for short-term rehabilitation therapy services, as described below, when prescribed by a **Physician** up to the benefit maximums listed on your *Schedule of Benefits*. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **Hospital**, **Skilled Nursing Facility**, or **Hospice Facility**;
- A **Home Health Care Agency**; or
- A **Physician**.

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. For inpatient rehabilitation benefits for the services listed below, refer to the Inpatient Hospital and Skilled Nursing Facility benefits provision under the **Covered Benefits** section of this **Contract**.

Physical therapy is covered provided the therapy is expected to:

- Significantly improve, develop or restore physical functions lost; or
- Improves any impaired function as a result of an acute illness, injury or surgical procedure.

Physical therapy does not include educational training.

Occupational therapy, (except for vocational rehabilitation or employment counseling), is covered provided the therapy is expected to:

- Significantly improve, develop or restore physical functions lost as a result of an acute illness, injury or surgical procedure; or
- Improve an impaired function as a result of an acute illness, injury or surgical procedure; or
- To relearn skills to significantly improve independence in the activities of daily living.

Occupational therapy does not include educational training.

Speech therapy is covered provided the therapy is expected to:

- Restore the speech function or correct a speech impairment resulting from illness or injury or;
- Improve delays in speech function development as a result of a gross anatomical defect present at birth.

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and

when the therapy is coordinated with **Aetna** as part of a treatment plan intended to restore previous cognitive function.

Spinal Manipulation Therapy
Covered benefits include charges made by a **physician** on an outpatient basis for therapeutic adjustments and manipulations for treating acute musculoskeletal conditions.

Habilitation Therapy Treatment
Covered Benefits include **habilitation** therapy services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**

Habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**, that:

- Details the treatment, and specifies frequency and duration, and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- Allows therapy services, provided in your home, if you are homebound.

Outpatient Physical, Occupational, and Speech Therapy

Covered Benefits under **Habilitation Therapy Treatment** include:

- Physical therapy, if it is expected to:
  - Develop any impaired function
- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to:
  - Develop any impaired function, or
  - Relearn skills to significantly develop your independence in the activities of daily living
- Speech therapy is covered provided the therapy is expected to:
  - Develop speech function as a result of delayed development

(Speech function is the ability to express thoughts, speak words and form sentences).

7. Other Covered Benefits

Acupuncture Benefit

Covered Benefits include charges made for acupuncture services provided by a licensed acupuncturist under the same conditions that apply to services of a licensed **physician.**

Administration of Blood and Blood Products

Covered Benefits include the administration of blood and blood products but not the cost of blood or blood products.

Ambulance Service

Covered Benefits include charges made by a professional **Ambulance**, as follows:

Ground Ambulance

Covered Benefits include charges for transportation:

- To the first **Hospital** where treatment is given in a medical emergency.
- From one **Hospital** to another **Hospital** in a medical emergency when the first **Hospital** does not have the required services or facilities to treat your condition.
- From **Hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **Hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient stay at a **Hospital**, **Skilled Nursing Facility** or acute rehabilitation **Hospital**, an **Ambulance** is required to safely and adequately transport you to or from inpatient or outpatient treatment.

Air or Water Ambulance

Covered Benefits include charges for transportation to a **Hospital** by air or water **Ambulance** when:

- Ground **Ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one **Hospital** to another **Hospital**; when the first **Hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **Hospital**; and the two conditions above are met.

Benefit Limitations:

Not covered under this benefit are charges incurred to transport you:

- If an **Ambulance** service is not required by your physical condition; or
- If the type of **Ambulance** service provided is not required for your physical condition; or
  By any form of transportation other than a professional **Ambulance** service; or
- Fixed wing air **Ambulance** from an out-of-network **provider**

Durable Medical Equipment (DME) Benefit

Covered Benefits include **Durable Medical Equipment** when **Precertified** by **Aetna**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the **Aetna** Medical Director has the authority to approve requests on a case-by-case basis. Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Contract**. **Aetna**

reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, is also covered upon precertification by **Aetna**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **Aetna** that:

- It is needed due to a change in the **Member's** physical condition; or
- It is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are a **Member's** responsibility.

Family Planning Services - *Other*

Covered Benefits include charges for the following family planning services, even though not provided to treat an illness or injury:

- Voluntary termination of pregnancy; and
- Voluntary sterilization for males.

Benefit Limitations:
Not covered under this benefit are charges incurred for:

- Voluntary termination of pregnancy;
- Male contraceptive methods or devices;
- Reversal of voluntary sterilization procedures, for males and females including related follow-up care;
- Charges for services which are covered to any extent under any other part of this plan; and
- Charges incurred for family planning services while confined as an inpatient in a **Hospital** or other facility.

Important Notes:

- Refer to the *Schedule of Benefits* for details about cost sharing and benefit maximums that apply to *Family Planning Services - Other*.
- For more information, see the sections on *Family Planning Services - Female Contraceptives*, *Pregnancy Expenses* and *Treatment of Infertility* in this **Contract**.

Hearing Aid Benefit

Covered Benefits include charges for hearing exams, prescribed hearing aids and hearing aid expenses as described below. This benefit is subject to an age limit as shown on the *Schedule of Benefits*.

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing; and
- Parts, attachments or accessories.

Covered Benefits include the following:

- Charges for an audiometric hearing exam and evaluation for a hearing aid prescription performed by:
  - A **Physician** certified as an otolaryngologist or otologist; or
  - An audiologist who (1) is legally qualified in audiology; or (2) holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- Charges for electronic hearing aids, installed in accordance with a **Prescription** written during a covered hearing exam;
- Any other related services necessary to access, select and adjust or fit a hearing aid.

Covered Benefits for hearing aids will not include per 36 consecutive month period:
- Charges for more than one hearing aid per ear; and
- Charges in excess of any maximum amount shown on the *Schedule of Benefits*.

Hearing Aids Alternate Treatment Rule

Sometimes there are several types of hearing aids that can be used to treat a medical condition, all of which provide acceptable results. When alternate hearing aids can be used, the plan's coverage may be limited to the cost of the least expensive device that is:
- Customarily used nationwide for treatment, and
- Deemed by the medical profession to be appropriate for treatment of the condition in question. The device must meet broadly accepted standards of medical practice, taking into account your physical condition.

You should review the differences in the cost of alternate treatment with your **Physician**. Of course, you and your **Physician** can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

This *Alternate Treatment Rule* provision will not operate to deny benefits as mandated by any applicable state statute or regulation.

Benefit Limitations:

No benefits are payable under this benefit for charges incurred for:
- A service or supply which is received while the person is not a covered person under this **Contract**;
- A replacement of:
  - A hearing aid that is lost, stolen or broken; or
  - A hearing aid installed within the prior 36 month period.
- Replacement parts or repairs for a hearing aid;
- Batteries or cords;
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss:
- Any ear or hearing exam performed by a **Physician** who is not certified as an otolaryngologist or otologist;
- Any hearing aid furnished or ordered because of a hearing exam that was done before the date the person became covered under this Plan;
- Any hearing care service or supply which is a **Covered Benefits** in whole or in part under any other part of this Plan;
- Any hearing care service or supply which does not meet professionally accepted standards;
- Any hearing exam:

- Required by an employer as a condition of employment; or
- Which an employer is required to provide under a labor agreement; or
- Which is required by any law of government.

- Hearing exams given during a stay in a **Hospital** or other facility, except those provided to newborns as part of the overall **Hospital** stay; and
- Any tests, appliances and devices for the improvement of hearing including hearing aid batteries and auxiliary equipment or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

Benefits after Termination of Coverage

This section applies only if a person's coverage terminates while the person is not "totally disabled" as defined in the Health Expense Benefits After Termination section.

Expenses incurred for hearing care with 30 days of termination of the person's coverage under this benefit section will be deemed to be covered hearing care expenses if:

- The prescription for the hearing aid was written; and
- The hearing aid was ordered;

during the 30 days before the date coverage ends.

Children's Early Intervention Services Benefit

Covered Benefits include those for children's early intervention services.

"Children's early intervention services", means services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act[, Part C, 20 United States Code, Section 1411, et seq.

Asthma Education

Covered benefits include and asthma education programs for covered persons with asthma and their families.

Amino Acid-Based Elemental Infant Formula

Covered Benefits includes amino acid-based elemental infant formula for children 2 years of age and under, regardless of the method of delivery of the formula, when a **Participating Provider** has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined under Maine law, that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A **Participating Provider** may be required to confirm and document ongoing **medical necessity** at least annually. **Covered Benefits** will be provided the same as any other medical expense.

Such documentation includes when a **Participating Provider** has diagnosed and through medical evaluation has documented one of the following conditions:

- Symptomatic allergic colitis or proctitis;

- Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis;
- A history of anaphylaxis;
- Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
- Cystic fibrosis; or
- Malabsorption of cow milk-based or soy milk-based infant formula.

Metabolic Formula/Special Low Protein Food Product

Covered Benefits include metabolic formula and special low-protein food products that have been prescribed by a **Participating Provider** for a **Member** with an inborn error of metabolism.

An inborn error of metabolism means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life.

A special modified low-protein food product means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

Morbid Obesity/Gastric Bypass

Covered Benefits include charges made for gastric bypass surgical procedures, including related outpatient services, for the surgical treatment of the morbid obesity of a covered person.

Prosthetic Appliances Benefit

Covered Benefits include the **Member's** initial provision and replacement of a prosthetic device (including certain orthotic devices such as braces, corsets and splints) that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects, when such device is prescribed by a **Participating Provider**, administered through a **Participating** or designated prosthetic **Provider** and precertified by **Aetna**. Coverage includes repair and replacement when due to growth and development or a significant change in a **Member's** physical condition. Repair and replacement due to loss, misuse, abuse or theft are not covered. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered. Covered prosthetic appliances include those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Contract**. **Aetna** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

Vision Care Benefits

Pediatric Routine Vision Exams

Covered Benefits include charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction and glaucoma testing.

This benefit is subject to an age limit as shown on the *Schedule of Benefits*.

Pediatric Vision Care Services and Supplies

Covered Benefits include charges for the following vision care services and supplies:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **Prescription** contact lenses.
- *Preferred* eyeglass frames, **Prescription** lenses or **Prescription** contact lenses identified by a vision **Participating Provider**. These are eyeglass frames, **Prescription** lenses, or **Prescription** contact lenses that are covered at 100% by a vision **Participating Provider**.
- *Non-Preferred* eyeglass frames, **Prescription** lenses or **Prescription** contact lenses that are not identified as *Preferred* by a vision **Participating Provider**.

Coverage includes charges incurred for:

- Non-conventional **Prescription** contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses.Aphakic **Prescription** lenses prescribed after cataract surgery has been performed. Low vision services.

This benefit is subject to an age limit as shown on the *Schedule of Benefits*.

A listing of the locations of the vision **Participating Providers** under this Plan can be accessed at the www.aetna.com website. Be sure to look at the appropriate vision **Participating Provider** listing that applies to your plan, since different **Aetna** plans use different networks of providers. You must present your ID card to the vision **Participating Provider** at the time of service.

This benefit is subject to the maximums shown on the Schedule of Benefits. As to coverage for **Prescription** lenses in a calendar year, this benefit will cover either **Prescription** lenses for eyeglass frames or **Prescription** contact lenses, but not both.

Benefit Limitations:

Unless specified above, not covered under this benefit are charges incurred for services and supplies:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **Prescription** contact lenses.
- Eyeglass frames, **Prescription** lenses and **Prescription** contact lenses that are not identified as *Preferred* by a vision **Participating Provider**.
- Eyeglass frames, non-**Prescription** lenses and non-**Prescription** contact lenses that are for cosmetic purposes.

EXCLUSIONS AND LIMITATIONS

Medical Exclusions

The following are not **Covered Benefits** except as described in the **Covered Benefits** section of this **Contract** or by amendment(s) attached to this **Contract**:

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Applied Behavioral Analysis and similar programs unless specifically described in this **Contract**.
- Behavioral health services that are not primarily aimed at treatment of illness, injury, restoration of physiological functions or that do not have a physiological or organic basis.
- Biofeedback, except as precertified by **Aetna**.
- Care for conditions that state or local laws require to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Certain **Transplant Occurrence**-related services or supplies including**:** treatment furnished to a donor when the **Transplant** recipient is not a **Member**; services and supplies not obtained from an **IOE**, including the harvesting or storage of organs without the expectation of immediate transplantation for an existing illness; harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness; outpatient **Prescription Drug**s not expressly related to an outpatient **Transplant** Occurrence; and home infusion therapy.
- Charges for **Transplant** expenses incurred within the first six months of continuous coverage under this **Contract**. This limitation may be reduced by the number of months of prior **Transplant** coverage the **Member** has on the **Effective Date of Coverage** under this **Contract,** if the **Member** has at least six months of such prior **Transplant** coverage.

  This limitation will not apply for a child during the first 12 months of life otherwise eligible for coverage under the Plan.

- Clinical trial therapies
  - Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
  - Services and supplies provided by the trial sponsor without charge to you
  - The experimental intervention itself (except Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).
-

- Contraception, except as specifically described in the ***Covered Benefit*** section including, but not limited to, over-the-counter contraceptive supplies such as condoms, contraceptive foams, jellies and ointments.

- Cosmetic Surgery, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an Aetna Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

- Court ordered services, or those required by court order as a condition of parole or probation.

- **Custodial Care.**

- Dental services except as specifically covered in the ***Covered Benefits*** section, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, bony impacted teeth, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts.

- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered. This exclusion does not apply to the Children's Early Intervention Services section.

- Experimental or Investigational Procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by **Aetna**, unless precertified by **Aetna**.

  This exclusion will not apply with respect to drugs:

  - That have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
  - That are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
  - **Aetna** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.

- **E-Visits** – Non-Contracted **Providers).**
  Any services that are given by **providers** that are not contracted with **Aetna** as **e-visit providers**. Any services that are not provided during an internet-based consult or via telephone.

- Foot Orthotics, unless required for the treatment of, or to prevent, complications of diabetes.

- Habilitation Therapy Services -- Physical, Occupational and Speech Therapy for Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**.
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist.

- Hair analysis.

- Hearing aids. Related services and supplies, except as specifically described in this **Contract**

- Home births.

- **Home Health Care.** Unless specified in *Covered Benefits* section:
  - Services or supplies that are not a part of the **home health care plan**;
  - Services of a person who usually lives with you, or who is a member of your, or your spouse's or your domestic partner's family;
  - Services for infusion therapy;
  - Transportation;
  - Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present; and
  - Services that are **custodial care**.
  - Services for applied behavior analysis.

- Home uterine activity monitoring.

- Household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a **Member's** house or place of business, and adjustments made to vehicles.

- Hypnotherapy, except when precertified by **Aetna**.

- Implantable drugs.

- Infertility. Any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, except as otherwise described in this **Contract.**
  -

- **Mental health treatment,** excpt as provided in the *Covered Benefits* section**..**

- Military service related diseases, disabilities or injuries for which the **Member** is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the

Member.

- Missed appointment charges.

- Non-**Medically Necessary** services, including but not limited to, those services and supplies:

  - Which are not **Medically Necessary**, as determined by **Aetna**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
  - That do not require the technical skills of a medical, mental health or a dental professional;
  - Furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**;
  - Furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and adequately be diagnosed or treated while not confined;
  - Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting.

- Nursing and aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

  - Outpatient infusion therapy services, other than as specifically described in the ***Covered Benefits*** section.

- Outpatient **Prescription** contraceptive drugs and devices services, other than as specifically described in the *Covered Benefits* section, including:

  - Oral drugs that are **brand-name Prescription Drugs** and **biosimilar Prescription Drugs**.
  - Injectable drugs that are **brand-name Prescription Drugs** and **biosimilar Prescription Drugs**.
  - Vaginal rings that are **generic Prescription Drugs**, **brand-name Prescription Drugs** and **biosimilar Prescription Drugs**.
  - Transdermal contraceptive patches that are **generic Prescription Drugs**, **brand-name Prescription Drugs** and **biosimilar Prescription Drugs**.
  - Female contraceptive devices that are brand-name devices.
  - FDA-approved female brand-name and biosimilar emergency contraceptives and brand-name over-the-counter (OTC) emergency contraceptives.
  - Other FDA-approved female and male brand-name over-the-counter (OTC) contraceptives.

- Outpatient supplies, including but not limited to, medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips.

- Payment for that portion of the benefit for which Medicare or another party is the primary payer.

- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other

like items and services.

- Prescription or non-**Prescription Drug**s and medicines, except as provided on an inpatient basis.

- Recreational and sleep therapy, including any related diagnostic testing.

- Religious, counseling, including services and treatment related to religious counseling, , and sex therapy.

- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.

- Routine foot/hand care, including routine reduction of nails, calluses and corns.

- Services for which a **Member** is not legally obligated to pay in the absence of this coverage**.**

- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

- Services, including those related to pregnancy, rendered before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation and Conversion section of this **Contract**.

- Services performed by a relative of a **Member** for which, in the absence of any health benefits coverage, no charge would be made.

- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

- Services which are not a **Covered Benefit** under this **Contract**.

- Short-Term Rehabilitation Services -- Outpatient Cognitive Rehabilitation, Physical, Occupational and Speech Therapy
  Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth.

  Except for physical therapy, occupational therapy or speech therapy provided for the treatment of delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:

  -
  - Any service unless provided in accordance with a specific treatment plan
  - Services you get from a **home health care agency**.

- Services provided by a **physician**, or treatment covered as part of the spinal manipulation benefit. This applies whether or not benefits have been paid under the spinal therapy benefit section.
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist.
-

- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

- Specific injectable drugs, including:

  - Experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);
  - Needles, syringes and other injectable aids;
  - Drugs related to the treatment of non-covered services; and
  - Drugs related to the treatment of **Infertility**, contraception, and performance enhancing steroids.

  Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

- **Telemedicine** Non-Contracting **Providers** Any services that are given by **providers** that are not contracted with **Aetna** as **Telemedicine providers.** Any services that are not provided during an internet-based consult or via telephone.

- Therapy or rehabilitation, including but not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide.

- Thermograms and thermography.

- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.

- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded **Members** in accordance with the benefits provided in the **Covered Benefits** section of this **Contract**.

- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or

injury which does. If a **Member** is covered under a Workers' Compensation law or similar law, and submits proof that the **Member** is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause.

- Unauthorized services obtained by the **Member** that require precertification by **Aetna** including but not limited to **Hospital** admissions and outpatient surgery. **Participating Providers** are responsible for obtaining precertification of **Covered Benefits** from **Aetna**.

- Vision: Vision-related services and supplies, except as described in the ***Covered Benefits*** section.

  In addition, the plan does not cover:

  - Special supplies such as non-**Prescription** sunglasses;
  - Vision service or supply which does not meet professionally accepted standards;
  - Special vision procedures, such as orthoptics or vision training;
  - Eye exams during your stay in a **Hospital** or other facility for health care;
  - Eye exams for contact lenses or their fitting;
  - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
  - Replacement of lenses or frames that are lost or stolen or broken;
  - Acuity tests;
  - Eye **Surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures;

  -Services to treat errors of refraction.

- Acupuncture and acupuncture therapy, except when performed by a **Participating Physician** as a form of anesthesia in connection with covered surgery.

- Temporomandibular joint disorder treatment (TMJ), including but not limited to, treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ.

- Voluntary termination of pregnancy.

Limitations

- In the event there are 2 or more alternative **Medical Services** which in the sole judgment of **Aetna** are equivalent in quality of care, **Aetna** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by **Aetna**, provided that **Aetna** pre-authorizes the **Medical Service** or treatment.

- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **Contract** are at the sole discretion of **Aetna,** subject to the terms of this **Contract**.

Outpatient Prescription Drugs

How the Pharmacy Plan Works

It is important that you have the information and useful resources to help you get the most out of your **Aetna Prescription Drug** plan. This **Contract** explains:

- How to access **Network Pharmacies** and procedures you need to follow;
- What **Prescription Drug** expenses are covered and what limits may apply;
- What **Prescription Drug** expenses are not covered by the plan;
- How you share the cost of your covered **Prescription Drug** benefit; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

A few important notes to consider before moving forward:

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your **Prescription Drug** plan pays benefits only for **Prescription Drug** expenses described in this **Contract** as **Covered Benefits**.
- This **Contract** applies to coverage only and does not restrict your ability to receive **Prescription Drugs** that are not or might not be covered benefits under this **Prescription Drug** plan.
- Store this **Contract** in a safe place for future reference.

Notice
The plan does not cover all **Prescription Drugs**, medications and supplies. Refer to the Limitations section of this coverage and *Exclusions* section of your **Contract**.

- **Covered Benefits** are subject to cost sharing requirements as described in the cost sharing sections of this coverage and in your *Schedule of Benefits*.
- **Specialty Prescription Drug** refills will only be covered when obtained through **Aetna's Specialty Network Pharmacy**.

This plan covers only certain **Prescription Drugs** in accordance with the plan that you elected and the **Preferred Drug Guide (Formulary)**. This plan does not cover all **Prescription Drugs**.

Accessing Pharmacies and Benefits

This plan provides access to **Covered Benefits** through a network of pharmacies, vendors or suppliers. Aetna has contracted for these **Network Pharmacies** to provide **Prescription Drugs** and other supplies to you.

Obtaining your benefits through **Network Pharmacies** has many advantages. Benefits and cost sharing may vary by the type of **network pharmacy** where you obtain your **Prescription Drug** and whether or not you purchase a brand-name or generic drug. **Network pharmacies** include retail, mail order and specialty **Pharmacies**.

To better understand the choices that you have with your plan, please carefully review the following information.

Accessing Network Pharmacies and Benefits

You may select a **Network Pharmacy** from the **Aetna** Network Pharmacy Directory or by logging on to **Aetna's** website at www.aetna.com. You can search **Aetna**'s online directory, DocFind, for names and locations of **Network Pharmacies**. If you cannot locate a **Network Pharmacy** in your area call Member Services.

You must present your ID card to the **Network Pharmacy** every time you get a **Prescription** filled to be eligible for network **Covered Benefits**. The **Network Pharmacy** will calculate your claim online. You will pay any deductible, copayment or coinsurance directly to the **Network Pharmacy**.

You do not have to complete or submit claim forms. The **Network Pharmacy** will take care of claim submission.

Emergency Prescriptions

When you need a **Prescription** filled in an emergency or **Urgent Care** situation, or when you are traveling, you can obtain network benefits by filling your **Prescription** at any **Network Retail Pharmacy**. The **Network Pharmacy** will fill your **Prescription** and only charge you your plan's cost sharing amount. If you access an **Non-Participating Pharmacy** you will pay the full cost of the prescription and will need to file a claim for reimbursement. You will be reimbursed for your **Covered Benefits** up to the cost of the **Prescription** less your plan's cost sharing for network benefits. Coverage for **Prescription Drugs** obtained from an **Non-Participating Pharmacy** is limited to those obtained in connection with **Emergency Care** and out-of-area **Urgent Care** services.

Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **Pharmacy**. Either **Aetna** or any **Network Pharmacy** may terminate the provider contract.

Cost Sharing for Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.
You will be responsible for the **Copayment** for each **Prescription** or refill as specified in the *Schedule of Benefits*. The **Copayment** is payable directly to the **Network Pharmacy** at the time the **Prescription** is dispensed.

- After you pay the applicable **copayment**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** amount is determined by applying the applicable **coinsurance** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing.

What the Pharmacy Benefit Covers

The plan covers charges for outpatient **Prescription Drugs** for the treatment of an illness or injury, subject to the Limitations section of this coverage and the *Medical Benefit* and *Pharmacy Benefit* Exclusions sections of the **Contract**. Prescriptions must be written by a prescriber licensed to prescribe federal legend **Prescription Drug**s.

This plan covers only certain **Prescription Drugs** in accordance with the plan that you elected and the **Preferred Drug Guide (Formulary)**. This plan does not cover all **Prescription Drugs**.

You may minimize your out-of-pocket expenses by selecting a **Generic Prescription Drug** when available.

Prescription drugs that are not listed on the **Preferred Drug Guide (Formulary)** are excluded from coverage unless a medical exception is approved by **Aetna**. Refer to the *Medical Exceptions* described below for details. In order for you to use a **Prescription Drug** not on the **Preferred Drug Guide (Formulary)**, you or your prescriber must request coverage as a medical exception.

Your **Prescription Drug** benefit may be subject to pharmacy management programs including, but not limited to **Precertification, Step Therapy,** quantity limits and drug utilization review. Refer to *Understanding Pharmacy Precertification* for further information.

Prescription Drugs covered by this plan are subject to drug and narcotic utilization review by **Aetna**, your **Provider** and/or your **Network Pharmacy**. This may include limiting access of **Prescription Drugs prescribed** by a specific **Provider**. Such limitation may be enforced in the event that Aetna identifies an unusual pattern of claims for **Covered Expenses.**

Retail Pharmacy Benefit

Outpatient **Prescription Drugs** are covered when dispensed by a retail **pharmacy**. Each **Prescription** is limited to the maximums shown in the *Schedule of Benefits***.**

Mail Order Pharmacy Benefit

Outpatient **Prescription Drugs** are covered when dispensed by a mail order pharmacy that is a **Network Pharmacy**. Each **Prescription** is limited to a maximum supply when filled at a mail order **Pharmacy** that is a **Network Pharmacy**. The maximums are shown in the *Schedule of Benefits.*

Outpatient **Prescription Drugs** are covered when dispensed by a **mail order pharmacy**. Each **Prescription** is limited to a maximum 30-90 day supply. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **Mail Order Pharmacy**.

See the *Schedule of Benefits* for details on supply limits and cost sharing.

Specialty Care Prescription Drug Benefit

Specialty Care Prescription Drugs (Specialty Care Drugs) are covered only when dispensed through a retail **Network Pharmacy** or a **Specialty Network Pharmacy**. Refer to **Aetna's** website, www.aetna.com to review the list of covered **Specialty Care Drugs.**

You are required to obtain **Specialty Care Drugs** at a **Specialty Network Pharmacy** for all **Prescription Drug** initial fills and refills.

Over-the-Counter Prescription Drug Benefit

Covered Benefits include certain over-the-counter medications, as determined by **Aetna**, in an equivalent prescription dosage strength for the **Generic Tier 1A, "Value Drugs",** appropriate member responsibility. Coverage of the selected over-the-counter medications requires a **prescription**. You can access the list by logging onto www.aetna.com.

Split Fill Dispensing Program

Aetna's split fill dispensing program is designed to prevent and/or minimize wasted **Prescription Drugs** if your **Prescription Drugs** or dose changes between fills, by allowing only a portion of your **Prescription** to be filled at a **Retail Pharmacy**. This program also saves you out of pocket expenses. The **Prescription Drugs** that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. You can access the list of these **Prescription Drugs** by calling the toll-free Member Services number on your member ID card or log on to your Aetna Navigator® secure member website at www.Aetna.com.

See the *Schedule of Benefits* for details on supply limits and cost sharing.

Other Covered Pharmacy Benefits

The following **Prescription Drugs**, medications and supplies are also **Covered Benefits** under this Coverage.

Smoking Cessation Drugs

Coverage of nicotine replacement therapy products and any other **prescription drugs** and medication specifically approved by the FDA for smoking cessation, including but not limited to, nicotine patches, gum or nasal spray.

Off-Label Use

U.S. Food and Drug Administration (FDA) approved **Prescription Drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your condition (including cancer and HIV/AIDS), subject to the following:

- The drug must be accepted as safe and effective to treat your symptom(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information);
  - Thomson Micromedex DrugDex System (DrugDex);
  - Clinical Pharmacology (Gold Standard, Inc.); or
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium; or
- Use for your symptom(s) has been proven as safe and effective by at least one well-designed controlled clinical trial. Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
  - The dosage of a drug for your symptom(s) is equal to the dosage for the same symptom(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above; or
  - The dosage has been proven to be safe and effective for your symptom(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Coverage of off-label use of these drugs may, in Aetna's discretion, be subject to **Precertification**, **Step Therapy** or other requirements or limitations.

Diabetic Supplies

Covered Expenses include but are not limited to the following diabetic supplies upon **Prescription** by a **Physician**:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

Contraceptives

Covered Benefits include charges made by a **Pharmacy** for the following contraceptive methods when prescribed by a prescriber and the **Prescription** is submitted to the pharmacist for processing:

- Female contraceptives that are **Prescription drugs** including emergency contraceptives that are included on the **Preferred Drug List (Formulary)**.
- Female contraceptive devices.

Benefits are payable under your medical or **Pharmacy** benefit depending on the type of expense and how and where the expense is incurred. Benefits are payable under your medical plan when charges are made by a **Physician** to insert or remove a **Prescription** drug or device.

Refer to your *Schedule of Benefits* for the *Female Contraceptives - Copayment and Deductible Waiver* provision for more information.

Oral Infertility Drugs

The following **Prescription Drugs** used for the purpose of treating infertility including, but not limited to Progesterone.

Understanding Pharmacy Precertification

Precertification is required for certain outpatient **Prescription Drugs**. prescriber**s** must contact **Aetna** or an affiliate to request and obtain coverage for such **Prescription Drugs**. The list of drugs requiring **Precertification** is subject to periodic review and modification by **Aetna**. An updated copy of the list of drugs requiring **Precertification** shall be available upon request or may be accessed on line and can be found in the **Aetna Preferred Drug Guide** available online at www.aetna.com.

How to Obtain Precertification

If an outpatient **Prescription drug** requires **Precertification** and you use a **Network Pharmacy** the prescriber is required to obtain **Precertification** for you.

Aetna will let your prescriber know if the **Prescription Drug** is **Precertified**.

If **Precertification** is denied **Aetna** will notify you how the decision can be appealed.

Step Therapy

Step Therapy is another form of **Precertification**. With **Step Therapy**, certain medications will be excluded from coverage unless one or more "prerequisite therapy" medications are tried first or unless the prescriber obtains a medical exception.

Lists of the **Step Therapy** drugs and prerequisite drugs are included in the **Preferred Drug Guide (Formulary)** available upon request or online at www.aetna.com. The list of step therapy drugs are subject to change by **Aetna**.

Prescribing Units

Depending on the form and packing of the product, some **Prescription Drugs** are limited to 100 units excluding insulin dispensed per **Prescription** order or refill. Drugs that are allowed to be filled with greater than 30 day supply at a **Retail Pharmacy** are excluded from the 100 unit limitation

Any **Prescription Drug** that has duration of action extending beyond one (1) month shall require the number of **Copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) **Copayments**.

Specialty Care Prescription Drugs[may have limited access or distribution and are limited to no more than a 30 day supply.

Medical Exceptions

Your prescriber may seek a medical exception to obtain coverage for drugs not listed on the **Preferred Drug Guide (Formulary)** or for which coverage is denied through **Precertification**. The prescriber must submit such exception requests to **Aetna**. Coverage granted as a result of a medical exception shall be based on an individual, case by case **Medical Necessity** determination and coverage will not apply or extend to other covered persons. If approved by **Aetna**, you will receive the non-preferred **network** benefit level as shown in your *Schedule of Benefits*

Pharmacy Benefit Limitations and Exclusions

Limitations

A **Network Pharmacy** may refuse to fill a **Prescription** order or refill when in the professional judgment of the pharmacist the **Prescription** should not be filled.

The plan will not cover expenses for any **Prescription Drug** for which the actual charge to you is less than the required **Copayment** [or **Deductible]**, or for any **Prescription Drug** for which no charge is made to you.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the **Contract**.

The number of **Copayments** you are responsible for per vial of Depo-Provera and/or Medroxyprogesterone, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

The plan will not pay charges for any **Prescription Drug** dispensed by a mail order **Pharmacy** for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

Exclusions

Not every health care service or supply is covered by the plan. Even if prescribed, recommended, or approved by your **Physician** it may not be covered. The plan covers only those services and supplies that are included in the ***Covered Benefits*** section. Charges made for the following are not covered except to the extent listed under the ***Covered Benefits*** section or by amendment attached to this **Contract**. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These **Prescription Drug** exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

- Administration or injection of any drug.
- All drugs or medications in a **therapeutic drug class** if one of the drugs in that **Therapeutic Drug Class** is not a **Prescription Drug**, unless **Medically Necessary**.
- Allergy sera and extracts.

- Any charges in excess of the benefit, day, or supply limits stated in this **Contract**.

- Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain **Prescription Drugs**, or supplies, even if otherwise covered under this **Contract**. This also includes **Prescription Drugs** or supplies if:

  - Such **Prescription Drug** or supplies are unavailable or illegal in the United States; or
  - The purchase of such **Prescription Drugs** or supplies outside the United States is considered illegal.

- Any drugs or medications, services and supplies that are not **Medically Necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the illness or injury involved. This applies even if they are prescribed, recommended or approved by your **Physician.**

- Any **Prescription Drug** or supply used for the treatment of sexual dysfunction/ enhancement in any form. Any **Prescription Drug** in any form that is in a similar or identical class; has a similar or identical mode of action; or exhibits similar or identical outcomes.

- **Brand-name Prescription Drugs** and devices when a **Generic Prescription Drug** or device equivalent, **Biosimilar Prescription Drug** or **Generic Prescription Drug** or device alternative is available, unless otherwise covered by medical exception.

- Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

- Certain **Prescription Drugs** but only to the extent such coverage is excluded under the plan that you elected and the **Preferred Drug Guide (Formulary)**.

- Contraceptives, except as specifically described in the *What the Pharmacy Benefit Covers* section including, but not limited to, over-the-counter contraceptive supplies such as condoms, contraceptive foams, jellies and ointments.

- Cosmetic drugs, medications or preparations used for cosmetic purposes or to promote hair growth, including but not limited to:

  - Health and beauty aids;
  - Chemical peels;
  - Dermabrasion;
  - Treatments;
  - Bleaching;
  - Creams;
  - Ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

- Drugs given by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

- Drugs given or entirely consumed at the time and place it is prescribed or dispensed.

- Drugs or medications that include the same active ingredient or a modified version of an active ingredient and:
  - Is therapeutically equivalent or therapeutically alternative to a covered **Prescription Drug** (unless medical exception is approved), or
  - Is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless medical exception is approved).

- Drugs recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Aetna's** Pharmacy and Therapeutic Committee.

- Drugs, services and supplies given in connection with treatment of an occupational injury or occupational illness.

- Drugs used primarily for the treatment of infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except as described in the ***Covered Benefits*** section.

- Drugs used for the purpose of weight gain or reduction, including but not limited to:

  - Stimulants;
  - Preparations;
  - Foods or diet supplements;
  - Dietary regimens and supplements;
  - Food or food supplements;
  - Appetite suppressants; and
  - Other medications.

- Drugs used for the treatment of obesity.

- **Durable medical equipment**, monitors and other equipment except as described in the *Covered Benefits* section.

- **Experimental or Investigational** drugs or devices, except as described in the *Covered Benefits* section.

  This exclusion will not apply with respect to drugs that:

  - Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
  - Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
  - **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the illness.

- Food items: Any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This limitation will not apply to formulas and special modified food products as specifically stated in this **Contract**.

- Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

- Immunization or immunological agents except as described in the *Covered Benefits* section.

- Implantable drugs and associated devices, except as described in the *Covered Benefits* section.

- Injectables or infused drugs, except as described in the *Covered Benefits* section.
  - Any charges for the administration of an infused or injected **Prescription Drug** or injectable insulin and other infused or injected drugs covered by **Aetna**;
  - Certain injectable agents such as injectable contrasts/dyes used for imaging (e.g., MRI, CT, Bone Scans), except insulin;
  - Needles and syringes except diabetic needles and syringes, or for a covered drug; and
  - Injectable drugs if an alternative oral drug is available.

- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

- **Prescription Drugs** for which there is an over-the-counter (OTC) product which has the same active ingredient even if a **Prescription** is written.

- **Prescription drugs** unless the drug is included on the **Preferred Drug Guide (Formulary)** or a medical exception is granted.

- **Prescription** orders filled prior to the effective date or after the termination date of coverage under this **Contract**.

- Prophylactic drugs for travel.

- Refills over the amount specified by the **Prescription** order. Before recognizing charges, **Aetna** may require a new **Prescription** or proof as to need, if a **Prescription** or refill appears excessive under accepted medical practice standards.

- Refills dispensed more than one year from the date the latest **Prescription** order was written, or as otherwise allowed by applicable law of the jurisdiction in which the drug is dispensed.

- Replacement of lost or stolen **Prescription**s.

- Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

- Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including but not limited to hormones and hormone therapy.

- Supplies, devices or equipment of any type, except as specifically provided in the *Covered Benefits* section.

- Test agents except diabetic test agents.

TERMINATION OF COVERAGE

A **Member's** coverage under this **Contract** will terminate upon the earliest of any of the conditions listed below and termination will be effective on the date indicated on the *Schedule of Benefits*.

When Coverage Ends For Covered Persons

Your coverage under this **Contract** will end if:

- You no longer meet the eligibility requirements of the plan;
- Your premium payment is not received by the end of the grace period;
- You terminate your coverage by notifying **Aetna** in writing 31 days in advance of the termination;
- Discontinuance, under federal or state law, of this product in the state if approved by the Insurance Department of the jurisdiction where this **Contract** was issued;
- **Aetna**'s withdrawal, under federal or state law, from the individual market in the state where this **Contract** was issued if approved by the Insurance Department of the jurisdiction where this **Contract** was issued.

Termination For Cause

Aetna may terminate coverage for cause:

- Upon 31 days advance written notice in the event that **Aetna** does not receive payment from the **Contract Holder** for the entire **Premium** due under this **Contract** within the grace period. Coverage will terminate as of the last day for which **Premiums** were received, subject to the grace period. The termination of this **Contract** following the expiration of the grace period shall not relieve the **Contract Holder** of its obligation to pay the **Premium** for coverage provided during the grace period. Upon 31 days advance written notice, if the **Member** has failed to make any required **Copayment** or any other payment which the **Member** is obligated to pay. Upon the effective date of such termination, prepayments received by **Aetna** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be refunded to **Contract Holder**.
- Upon 30 days advance written notice, if the **Member** refuses to cooperate and provide any facts necessary for **Aetna** to administer the **Coordination of Benefits** provisions set forth in this **Contract**.
- Immediately, upon discovery of a material misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **Contract** or upon discovery of the **Member's** commission of fraud against **Aetna**. This may include, but is not limited to, furnishing incorrect or misleading information to **Aetna**, or allowing or assisting a person other than the **Member** named on the identification card to obtain **Aetna** benefits. **Aetna** may, at its discretion, rescind a **Member's** coverage on and after the date that such misrepresentation or fraud occurred. In the absence of fraud or material misrepresentation, all statements made by any **Member** or any person applying for coverage under this **Contract** will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage or reduction of benefits unless the statement is contained in writing and signed by the **Member**, and a copy of same has been furnished to the **Member** prior to termination.

Coverage will not be terminated on the basis of a **Member's** health status or health care needs, nor if a **Member** has exercised the **Member's** rights under the **Contract's** Complaints and Appeals, **External Review**, and Dispute Resolution sections to register a **Complaint** with **Aetna**. The **Complaint** process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination for Cause subsection of the **Contract**.

No termination shall relieve the **Contract Holder** from any obligation incurred prior to the date of termination of this **Contract**.

Aetna shall have no liability or responsibility under this **Contract** for services provided on or after the date of termination of coverage.

CONTINUATION AND CONVERSION

Continuation Coverage for Dependents

If a **Subscriber** dies while covered under this **Contract**, any coverage then in force for the **Covered Dependents** will be continued, provided the **Contract Holder** continues to make **Premium** payments. A **Subscriber's** spouse's coverage will cease when the spouse remarries. Any **Covered Dependent's** coverage, including a spouse's, will cease upon the earliest of:

- The end of the month period right after the **Subscriber's** death;
- A **Covered Dependent** no longer meets the eligibility requirements as outlined in this **Contract**;
- A **Covered Dependent** becomes eligible for similar coverage under this plan or any other plan providing group health benefits;
- When the **Contract Holder** no longer provides coverage for the class of eligible enrollees of which the **Subscriber** was part of right before the **Subscriber's** death; or
- Any required contributions cease.

If coverage is being continued for a **Covered Dependent**, a **Subscriber's** child born after the **Subscriber's** death will also be covered.

Continuation Coverage for Dependent Students on Medical Leave of Absence

If a **Member**, who is eligible for coverage and enrolled in **Aetna** by reason of his or her status as a full-time student at a postsecondary educational institution, ceases to be eligible due to:

- A **Medically Necessary** leave of absence from school; or
- A change in his or her status as a full-time student,

resulting from a serious illness or injury, such **Member's** coverage under [the **Contract** and] this **Contract** may continue.

Any **Covered Dependent's** coverage provided under this continuation provision will cease upon the first to occur of the following events:

- The end of the 12 month period following the first day of the dependent child's leave of absence from school, or change in his or her status as a full-time student;
- The dependent child's coverage would otherwise end under the terms of this plan;
- The **Contract Holder** discontinues dependent coverage under this plan; or
- The **Subscriber** fails to make any required premium payments toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence or the change in his or her status as a full-time student.

In order to continue coverage for a dependent child under this provision, the **Subscriber** must notify **Aetna** as soon as possible after the child's leave of absence begins or a change in full time student

status occurs. **Aetna** may require a written certification from the treating **physician** which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or other change in full-time student status) is **Medically Necessary**.

If:

- A dependent child's eligibility under a prior plan is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a **Medically Necessary** leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

coverage under **Aetna** will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided above.

Continuation of Coverage During Temporary Lay-off or Approved Leave of Absence

If a **Subscriber's** coverage would terminate due to a temporary lay-off or an approved leave of absence, coverage may be continued for up to 30 days, or as otherwise agreed to between **Aetna** and **Contract Holder**, if the **Contract Holder**: (1) pays the **Premium** for such continued coverage; and (2) provides continued coverage from **Aetna** or its other sponsored health benefit plans to all eligible enrollees in the same class as the **Subscriber** whose coverage would otherwise terminate because of a temporary lay-off or approved leave of absence.

Extension of Benefits While Member is Receiving Inpatient Care

Any **Member** who is receiving inpatient care in a **Hospital** or **Skilled Nursing Facility** on the date coverage under this **Contract** terminates is covered in accordance with the **Contract** only for the specific medical condition causing that confinement or for complications arising from the condition causing that confinement, until the earlier of:

- The date of discharge from such inpatient stay;
- Determination by the **Aetna** Medical Director in consultation with the attending **Physician**, that care in the **Hospital** or **Skilled Nursing Facility** is no longer **Medically Necessary**;
- The date the contractual benefit limit has been reached;
- The date the **Member** becomes covered for similar coverage from another health benefits plan; or
- 12 months of coverage under this extension of benefits provision.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage.

Extension of Benefits Upon Total Disability

Any **Member** who is **Totally Disabled** on the date coverage under this **Contract** terminates is covered in accordance with the **Contract**.

This extension of benefits shall only:

- Provide **Covered Benefits** that are necessary to treat medical conditions causing or directly related to the disability as determined by **Aetna**; and
- Remain in effect until the earlier of the date that:

    - The **Member** is no longer **Totally Disabled**;
    - The **Member** has exhausted the **Covered Benefits** available for treatment of that condition;
    - The **Member** has become eligible for coverage from another health benefit plan which does not exclude coverage for the disabling condition; or
    - After a period of 12 months in which benefits under such coverage are provided to the **Member**.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage.

Conversion Privilege

(Note: This section does NOT continue insurance coverage under this Contract. It provides for issue of another contract).

If a Member's coverage under this Contract (other than the Subscriber) terminates such Member may be issued the same individual coverage provided by this Contract (referred below as the "**Contract**"). Written application for the converted contract must be made and the first premium paid to **Aetna** within 31 days after the termination. Upon notification by the Member to **Aetna** of a request for conversion, **Aetna** shall mail an election and premium notice form, including an outline of coverage.

The contract will not violate any law or regulation. **Aetna**, on request, will give details of the contract.

The contract will be equal to or, at the option of the Member, less than the amount of health insurance which ceases because of such termination.

The conversion contract may reduce its benefits by any continued benefits paid under this Contract.

The **Contract** may permit the **Aetna** to ask at a premium due date if a Member is then covered for like benefits by another **Contract** as stated in the preceding paragraph. If a person is so covered and fails to give details, the benefits paid under the contract may be based on the actual expenses less expenses paid by such other coverage.

Aetna may decline to:

- Issue the contract if application is not made in a place where **Aetna** is authorized to issue it.
- Cover a person for any benefit in the **Contract**, if such benefit is not legal.

The first Premium payment will be **Aetna's** then usual rate for the applicant's class of risk, and the age of each Member.

The contract will take effect on the day after this Contract terminates.

DISPUTE RESOLUTION, CLAIMS PROCEDURE, COMPLAINTS AND APPEALS AND EXTERNAL REVIEW

CLAIM PROCEDURES

A claim occurs whenever a **Member** or the **Member's** authorized representative requests pre-authorization as required by the plan from **Aetna**, a **Referral** as required by the plan from a **Participating Provider** or requests payment for services or treatment received. As a **Member**, most claims do not require forms to be submitted. However, if a **Member** receives a bill for **Covered Benefits**, the bill must be submitted promptly to the **HMO** for payment. Send the itemized bill for payment with the **Member's** identification number clearly marked to the address shown on the **Member's** ID card.

Aetna will make a decision on the **Member's** claim. Notice of the benefit determination on the claim will be provided to the **Member** within the below timeframes. Under certain circumstances, these time frames may be extended. If **Aetna** makes an **adverse benefit determination**, notice will be provided in writing to the **Member**, or in the case of a concurrent care claim, to the **Participating Provider**. The notice will provide important information about making an **Appeal** of the **adverse benefit determination**.

"**Adverse benefit determinations**" are decisions made by **Aetna** that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service or termination of a **Member's** coverage back to the original effective date (rescission). Such adverse benefit determination may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is an **Experimental or Investigational Procedure**.
- A decision that the service or supply is not **Medically Necessary**. If a **Provider** or **Member** will not release clinically relevant, necessary information for review, **Aetna** may deny certification of the services.

A "**final adverse benefit determination**" is an **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

Aetna Timeframe for Notification of a Benefit Determination	
Type of Claim	**Response Time from Receipt of Claim**
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible, but not later than [24-48] hours after the claim is made. If more information is needed to make an **Urgent Care Claim** decision, **Aetna** will notify the claimant within [24-48] hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur: • the receipt of the additional information; or • the end of the 48 hour period given the **Physician** to provide **Aetna** with the information.
Pre-Service Claim. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care.	Within 2 working days after obtaining all necessary information. **Aetna** will not later render an adverse decision with respect to any pre-authorized services except if fraudulent or materially incorrect information was provided at the time the services were pre-authorized, and such information was used in pre-authorizing the

	services.

Aetna Timeframe for Notification of a Benefit Determination (continued)	
Concurrent Care Claim Extension. A request to extend a course of treatment previously pre-authorized by **Aetna**.	Within one working day of obtaining all necessary information.
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously pre-authorized by **Aetna**.	Within one working day of obtaining all necessary information. If the **Member** files an **Appeal**, **Covered Benefits** under the **Certificate** will continue for the previously approved course of treatment until a final **Appeal** decision is rendered. During this continuation period, the **Member** is responsible for any **Copayments** and **Deductibles** that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **Appeal**. If **Aetna's** initial claim decision is upheld in the final **Appeal** decision, the **Member** will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.
Retrospective Claim. A claim for a benefit that is not a pre-service claim.	Within 30 calendar days of obtaining all necessary information.

Requests for Reconsideration of an Adverse Utilization Review Determination. For an initial or concurrent review determination, the **Provider** rendering the service can request, by telephone, fax or in writing, a reconsideration on behalf of the **Member**. The reconsideration will occur within one (1) working day of the receipt of the request, and will be conducted between the **Provider** rendering the service and the reviewer who made the adverse determination or a qualified health care professional designated by the reviewer, if the reviewer cannot be available within one (1) working day. If the reconsideration process does not resolve the difference of opinion, the adverse determination may be appealed by the **Member** or by the **Provider** on the **Member's** behalf. A reconsideration is not required before appealing an adverse determination.

COMPLAINTS AND APPEALS

HMO has procedures for **Members** to use if they are dissatisfied with a decision that **Aetna** has made or with the operation of the **Aetna**. The procedure the **Member** needs to follow will depend on the type of issue or problem the **Member** has.

- **Appeal.** An **Appeal** is a request to **Aetna** to reconsider an **adverse benefit determination**. The **Appeal** procedure for an **adverse benefit determination** has one; level(s).

- **Complaint.** A **Complaint** is an expression of dissatisfaction about the quality of care or the operation of **Aetna**.

- **External Review.** A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the Commissioner of the Maine Bureau of Insurance and made up of **Physicians** or other appropriate **Providers**. The ERO must have expertise in the problem or question involved.

A. **Complaints**.

If the **Member** is dissatisfied with the administrative services the **Member** receives from **Aetna** or wants to complain about a **Participating Provider,** call or write Member Services. The **Member** will need to include a detailed description of the matter and include copies of any records or documents that the **Member** thinks are relevant to the matter. **Aetna** will review the information and provide the **Member** with a written response within a reasonable timeframe of the receipt of the **Complaint**, unless additional information is needed and it cannot be obtained within this time frame. The response will tell the **Member** what the **Member** needs to do to seek an additional review.

B. **Full and Fair Review of Claim Determinations and Appeals**

Aetna will provide the **Member** with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to the **Member** in advance of the date on which the notice of the **final**

adverse benefit determination is required to be provided so that the **Member** may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, the **Member** must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

C. **Appeals of Adverse Benefit Determinations.**

The **Member** will receive written notice of an **adverse benefit determination** from **Aetna**. The notice will include the reason for the decision and it will explain what steps must be taken if the **Member** wishes to **Appeal.** The notice will also identify the **Member's** rights to receive additional information that may be relevant to an **Appeal**. Requests for an **Appeal** must be made in writing within a reasonable timeframe from the date of the notice. Except for Urgent Care Claims, an acknowledgement letter will be sent to you within three (3) working days of **Aetna's** receipt of the appeal. The letter will contain the name; address; and telephone number of the Appeal Coordinator assigned to review the appeal. If the appeal concerns medical necessity; appropriateness; health care setting; level of care; or effectiveness the Coordinator will be a clinical peer health care professional. If the letter requests additional information, it must be sent to **HMO** within the next 15 days.

A **Member** may also choose to have another person (an authorized representative) make the **Appeal** on the **Member's** behalf by providing **Aetna** with written consent. However, in case of an urgent care claim or a pre-service claim, a **Physician** may represent the **Member** in the **Appeal**.

A **Member** may be allowed to provide evidence or testimony during the **Appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Aetna provides for one level of **Appeal** of the **adverse benefit determination**. The **Member** must complete all steps in the **Aetna Appeals** process before bringing a lawsuit against **Aetna**. A **final adverse benefit determination** notice may provide an option to request an **External Review** *(if available)*. The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

Type of Claim	**Level One Appeal HMO Response Time from Receipt of Appeal**
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or	Within 36 hours Review provided by **Aetna** personnel not involved in making the **adverse benefit determination**.

subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	

Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 15 calendar days or receipt of any additional information requested. Review provided by **HMO** personnel not involved in making the **adverse benefit determination**.
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	Within one working day of obtaining all necessary information.
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously pre-authorized by **Aetna**.	Within one working day of obtaining all necessary information.
Retrospective Claim. Any claim for a benefit that is not a pre-service claim.	Within 30 calendar days or receipt of any additional information requested. Aetna will notify you in writing within 5 working days after making the determination. Review provided by **Aetna** personnel not involved in making the **adverse benefit determination**.

If **Aetna's** final decision is an adverse decision, it will contain:

- The names; titles; and qualifying credentials of the person(s) involved in the review;

- A statement of the Coordinator's understanding of the Appeal; and all pertinent facts;
- The specific plan provisions upon which the decision is based.
- The Coordinator's basis for the decision in clear terms;
- A reference to the evidence; or documentation; used as the basis for the decision; and instructions for requesting copies of such materials;
- A notice of your right to contact the Maine Bureau of Insurance, including the address and telephone number of the Bureau;
- The availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act;
- Notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process;
- Any other information required pursuant to the federal Affordable Care Act.

D. **Exhaustion of Process.**

The foregoing procedures and process are mandatory and must be exhausted prior to The establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the **Contract** by **Aetna,** or any matter within the scope of the **Complaints** and **Appeals** process.

Under certain circumstances a **Member** may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include Urgent Care Claims and situations where the **Member** is receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

If **Aetna** does not adhere to all **adverse benefit determination** and **Appeal** requirements (including required timeframes for issuing decisions) of the state of Maine and of the Federal Department of Health and Human Services, the **Member** is considered to have exhausted the **Appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or an **appeal** straight to an **External Review**. A **Member's** claim or internal **Appeal** *will not* go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm the **Member**;
- it was for a good cause or was beyond **HMO's** control; and
- it was part of an ongoing, good faith exchange between the **Member** and **Aetna**.

E. **Record Retention.**

Aetna shall retain the records of all **Complaints** and **Appeals** for a period of at least 7 years.

F. **Fees and Costs.**

Nothing herein shall be construed to require **Aetna** to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a **Complaint** or **Appeal**.

Maine Bureau of Insurance Assistance

The **Member** or his or her designated representative has the right to contact the Maine Bureau of Insurance for assistance at any time. The address is:

Department of Professional and Financial Regulation
Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

The consumer toll free number is 1-800-300-5000.

EXTERNAL REVIEW

Under certain circumstances, the **Member,** or the **Member's** representative, has the right to an external review of a denial of coverage. Specifically, if **Aetna** has denied coverage on the basis that the service is not **Medically Necessary**, or is an experimental or investigational treatment.

1. The **Member** must file a written request for external review with the Superintendent of Insurance within 12 months from the date the **Member** receives a final adverse health care treatment decision under **Aetna's** Complaints and Appeals section.

2. Prior to requesting an external review the **Member** must either:

   a. exhaust the first and second levels of the Complaint and Appeal section; or

   b. meet the criteria for expedited review.

3. **Aetna** must advise the **Member** on notices of adverse health care treatment that expedited external review is available:

   a. if **Aetna** has failed to issue a written decision on an internal appeal or grievance within the required time periods, and the delay is the fault of **Aetna**;

   b. **Aetna** and **Member** mutually agree in writing to bypass the internal Complaint and Appeal procedures;

   c. **Member** has a medical condition where the timeframe for **Aetna's** internal Complaint and Appeal section could result in serious jeopardy to the life or health of the **Member**, or could jeopardize the **Member's** ability to regain maximum function;

   d. A **Member's** representative may request an expedited external review if the **Member** has died.

4. A written Notice of Decision is due within 30 days from the date the external review entity receives the case from the Maine Bureau of Insurance, unless the **Member** requests and is granted an expedited review. A decision on a request for an expedited review must be made by the expedited review entity within 72 hours of receipt of a completed request for an expedited review.

5. **Member** and/or the **Member's** representative has the right to:

   a. attend the external review;

   b. submit and obtain supporting materials relating to the adverse health care treatment under review;

   c. ask questions of any representative of **Aetna** and have outside assistance.

6. **Aetna** must provide, within 5 days of the notification by the Maine Bureau of Insurance that an external review has been requested, copies of the following to the Bureau if in possession of **Aetna** or available to **Aetna** from a **Participating Provider**:

   a. copies of all medical records, clinical criteria and other records considered by **Aetna** in reaching its adverse health care treatment decision;

   b. **Member** may request a copy of the transcript of any appeal hearing be included in the record for external review, if such transcript has been made by **Aetna**;

   c.all relevant clinical information relating to the **Member's** physical and mental condition;

d. recommendation of the attending **Provider**;

e. terms of coverage under the **Member's** health plan with **Aetna**;

f. all clinical standards and guidelines relied upon by **Aetna** or **Aetna's** Claim Procedure/Complaint and Review entity in rendering the health care treatment decision under review; and

g. all other documents pertaining to the health care treatment under review.

7. **Aetna** must provide any additional information requested by the external review entity, Maine Bureau of Insurance, **Member** or **Member's** representative. Requests may be made by telephone, in writing, via facsimile or by e-mail. Additional information, documents or records requested from **Aetna** must be provided within 5 days unless an extension is requested and granted by the Maine Bureau of Insurance. In the case of an expedited review, **Aetna** must provide the requested information as expeditiously as the **Member's** condition requires.

8. If **Aetna** wishes to exercise its right to attend the external review hearing, **Aetna** must give written notification to the external review entity, Maine Bureau of Insurance, **Member** and/or **Member's** representative within 5 days of notification of the request for external review by the Maine Bureau of Insurance.

9. **Aetna** is required to pay for the cost of the external review.

10. **Aetna** will provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by a **Member** who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an **Member** who is visually impaired to allow the **Member** to exercise their rights to an external review.

11. External review decision is binding on **Aetna**. A **Member** and/or **Member's** representative may not file a request for a subsequent external review involving the same adverse health care treatment decision for which the **Member** and/or **Member's** representative has already received an external review decision.

DISPUTE RESOLUTION

Any controversy, dispute or claim between **Aetna** on the one hand and one or more **Interested Parties** on the other hand arising out of or relating to the **Contract**, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"), shall be settled by confidential binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole

neutral arbitrator shall be appointed upon petition to a court having jurisdiction. **Aetna** and **Interested Parties** hereby give up their rights to have Claims decided in a court before a jury.

Any Claim alleging wrongful acts or omissions of **Participating** or non-participating **Providers** shall not include **Aetna**. A **Member** must exhaust all **Complaint**, **Appeal** and independent external review procedures prior to the commencement of an arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) **Aetna** has made available independent external review and (ii) **Aetna** has followed the reviewer's decision. Punitive damages may not be recovered as part of a Claim under any circumstances. No **Interested Party** may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the **Contract**. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

SUBROGATION AND RIGHT OF REIMBURSEMENT

As used herein, the term "Third Party" means any party that is, or may be, or is claimed to be responsible for injuries or illness to a **Member**. Such injuries or illness are referred to as "Third Party injuries." "Responsible Party" includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of Third Party injuries.

If this Plan provides benefits under this **Contract** to a **Member** for expenses incurred due to Third Party injuries, then **Aetna** retains the right to repayment of the full cost of all benefits provided by this Plan on behalf of the **Member** that are associated with the Third Party injuries. **Aetna's** rights of recovery apply to any recoveries made by or on behalf of the **Member** from any sources, including but not limited to: payments made by a Third Party or any insurance company on behalf of the Third Party; any payments or awards under an uninsured or underinsured motorist coverage **Contract**; any Workers' Compensation or disability award or settlement; medical payments coverage under any automobile **Contract**, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a **Member** for Third Party injuries.

By accepting benefits under this Plan, the **Member** specifically acknowledges **Aetna's** right of subrogation. When this Plan provides health care benefits for expenses incurred due to Third Party injuries, **Aetna** shall be subrogated to the **Member's** rights of recovery against any party to the extent of the full cost of all benefits provided by this Plan. **Aetna** may proceed against any party with or without the **Member's** consent.

By accepting benefits under this Plan, the **Member** also specifically acknowledges **Aetna**'s right of reimbursement. This right of reimbursement attaches when this Plan has provided health care benefits for expenses incurred due to Third Party injuries and the **Member** or the **Member's** representative has recovered any amounts from any sources, including but not limited to: payments made by a Third Party or any insurance company on behalf of the Third Party; any payments or awards under an uninsured or underinsured motorist coverage **Contract**; any Workers' Compensation or disability award or settlement; medical payments coverage under any automobile **Contract**, premises or homeowners medical payments

coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a **Member** for Third Party injuries. By providing any benefit under **Contract**, **Aetna** is granted an assignment of the proceeds of any settlement, judgment or other payment received by the **Member** to the extent of the full cost of all benefits provided by this Plan. **Aetna's** right of reimbursement is cumulative with and not exclusive of **Aetna'**s subrogation right and **Aetna** may choose to exercise either or both rights of recovery. By accepting benefits under this Plan, the **Member** and the **Member's** representatives further agree to:

- Notify **Aetna** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party injuries sustained by the **Member**;

- Cooperate with **Aetna**, provide **Aetna** with requested information, and do whatever is necessary to secure **Aetna's** rights of subrogation and reimbursement under this **Contract**;

- Give **Aetna** a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);

- Pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due **Aetna** as reimbursement for the full cost of all benefits associated with Third Party injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement, and regardless of whether such payment will result in a recovery to the **Member** which is insufficient to make the **Member** whole or to compensate the **Member** in part or in whole for the damages sustained), unless otherwise agreed to by **Aetna** in writing; and

- Do nothing to prejudice **Aetna**'s rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this Plan.

- Serve as a constructive trustee for the benefit of this Plan over any settlement or recovery funds received as a result of Third Party injuries.

Aetna may recover the full cost of all benefits provided by this Plan under this **Contract** without regard to any claim of fault on the part of the **Member**, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from **Aetna'**s recovery, and **Aetna** is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by the **Member** to pursue the **Member's** claim or lawsuit against any Responsible Party without the prior express written consent of **Aetna.** In the event the **Member** or the **Member's** representative fails to cooperate with **Aetna**, the **Member** shall be responsible for all benefits provided by this Plan in addition to costs and attorney's fees incurred by **Aetna** in obtaining repayment.

RECOVERY RIGHTS RELATED TO WORKERS' COMPENSATION

If benefits are provided by **Aetna** for illness or injuries to a **Member** and **Aetna** determines the **Member** received Workers' Compensation benefits for the same incident that resulted in the illness or injuries, **Aetna** has the right to recover as described under the Subrogation and Right of Recovery provision. **Aetna** will exercise its Recovery Rights against the **Member**.

The Recovery Rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are paid by means of settlement or compromise;
- No final determination is made that bodily injury or sickness was sustained in the course of or resulted from the Member's employment;
- The amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the **Member** or the Workers' Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

By accepting benefits under this Plan, the **Member** or the **Member's** representatives agree to notify **Aetna** of any Workers' Compensation claim made, and to reimburse **Aetna** as described above.

RESPONSIBILITY OF MEMBERS

- **Members** or applicants shall complete and submit to **Aetna** such application or other forms or statements as **Aetna** may reasonably request. **Members** represent that all information contained in such applications, forms and statements submitted to **Aetna** incident to enrollment under this **Contract** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.

- The **Member** shall notify **Aetna** immediately of any change of address for the **Member** or any of the **Subscriber's Covered Dependents.**

- The **Member** understands that **Aetna** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.

- By electing coverage pursuant to this **Contract**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions in this **Contract**.

- **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

GENERAL PROVISIONS

Identification Card

The identification card issued by **Aetna** to **Members** pursuant to this **Contract** is for identification purposes only. Possession of an **Aetna** identification card confers no right to services or benefits under this **Contract**, and misuse of such identification card may be grounds for termination of **Member's** coverage pursuant to the Termination of Coverage section of this **Contract**. If the **Member** who misuses the card is the **Subscriber**, coverage may be terminated for the **Subscriber** as well as any of the **Covered Dependents**. To be eligible for services or benefits under this **Contract**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **Contract** have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this **Contract** shall be charged for such services or benefits at billed charges.

If any **Member** permits the use of the **Member's Aetna** identification card by any other person, such card may be retained by **Aetna**, and all rights of such **Member** and their **Covered Dependents**, if any, pursuant to this **Contract** shall be terminated immediately, subject to the Claim Procedures/Complaints and Appeals/Dispute Resolution in this **Contract**.

Reports and Records

Aetna is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **Contract** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Contract**. By accepting coverage under this **Contract**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered hereunder, authorizes each and every **Provider** who renders services to a **Member** hereunder to:

- Disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **Aetna**, or a medical, dental, or mental health professional that **Aetna** may engage to assist it in reviewing a treatment or claim;
- Render reports pertaining to the care, treatment and physical condition of the **Member** to **Aetna**, or a medical, dental, or mental health professional that **Aetna** may engage to assist it in reviewing a treatment or claim; and
- Permit copying of the **Member's** records by **Aetna**.

Refusal of Treatment

A **Member** may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Participating Provider**. If the **Participating Provider** (after a second **Participating Provider's** opinion, if requested by **Member**) believes that no professionally acceptable alternative exists, and if after being so advised, **Member** still refuses to follow the recommended treatment or procedure, neither the **Participating Provider**, nor **Aetna**, will have further responsibility to provide any of the benefits available under this **Contract** for treatment of such condition or its consequences or related conditions. **Aetna** will provide written notice to **Member** of a decision not to provide further benefits for a particular condition. This decision is subject to the Claim Procedures/Complaints and Appeals/Dispute Resolution in this **Contract**. Coverage for treatment of the condition involved will be resumed in the event **Member** agrees to follow the recommended treatment or procedure.

Assignment of Benefits

All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.

Legal Action

No action at law or in equity may be maintained against **Aetna** for any expense or bill unless and until the appeal process has been exhausted, and in no event prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in the **Contract**. No action shall be brought after the expiration of 3 years after the time written submission of claim is required to be furnished.

Independent Contractor Relationship

- **Participating Providers**, non-participating **Providers**, institutions, facilities or agencies are neither agents nor employees of **Aetna**. Neither **Aetna** nor any **Member** of **Aetna** is an agent or employee of any **Participating Provider**, non-participating **Provider**, institution, facility or agency.

- Neither the **Contract Holder** nor a **Member** is the agent or representative of **Aetna**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which **Aetna** has made or hereafter shall make arrangements for services under this **Contract**.

- **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all **Medical Services** which are rendered by **Participating Physicians**.

- **Aetna** cannot guarantee the continued participation of any **Provider** or facility with **Aetna**. In the event a **PCP** terminates its contract or is terminated by **Aetna**, **Aetna** shall provide notification to **Members** in the following manner:

  - Within 30 days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and
  - Services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the Provider Agreement and 5 business days after notification of the contract termination is mailed to the **Member** at the **Member's** last known address shall continue to be **Covered Benefits**.

- **Restriction on Choice of Providers:** Unless otherwise approved by **Aetna**, **Members** must utilize **Participating Providers** and facilities who have contracted with **Aetna** to provide services.

Inability to Provide Service

If due to circumstances not within the reasonable control of **Aetna**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Provider Network, the provision of medical or **Hospital** benefits or other services provided under this **Contract** is delayed or rendered impractical, **Aetna** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **Aetna** on the date such event occurs. **Aetna** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

Confidentiality

Information contained in the medical records of **Members** and information received from any **Provider** incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for a **Member's** care or treatment, the operation of **Aetna** and administration of this **Contract**, or other activities, as permitted by applicable law. **Members** can obtain a copy of **Aetna's** Notice of Information Practices by calling the Member Services toll-free telephone number listed on the **Member's** identification card.

Limitation on Services

Except in cases of **Emergency Services** or **Urgent Care**, or as otherwise provided under this **Contract**, services are available only from **Participating Providers** and **Aetna** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any **Physician**, **Hospital**, **Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by **Aetna**.

Incontestability

In the absence of fraud, all statements made by a **Member** shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim after the **Contract** has been in force for 2 years from its effective date, unless the statement was material to the risk and was contained in a written application.

Effect of Benefits Under Other Plans

Non-Duplication of **Aetna** Benefits

If, while covered under this plan, you are also covered by another **Aetna** individual coverage plan:

- You will be entitled only to the benefits of the plan with the greater benefits, and
- **Aetna** will refund any premium charges received under the plan with the lesser benefits covering the time period both plans were in effect. However, any claims payments made by **Aetna** under the plan with the lesser benefits will be deducted from any such refund of premium.

If while covered under this plan, you are also covered under an **Aetna** group plan:

- You will be entitled only to the benefits of the group plan.
- We will refund any premium received under the individual plan covering the period both plans were in effect. However, any claims payments made by **Aetna** under the individual plan will be deducted from any such refund of premium.

Additional Provisions

The following additional provisions apply to your coverage:

- This **Contract** applies to coverage only, and does not restrict a **Member's** ability to receive health care benefits that are not, or might not be, **Covered Benefits**.

- The **Contract** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the Maine Bureau of Insurance. This can also be done by mutual written agreement between **Aetna** and **Contract Holder** without the consent of **Members**.

- **Aetna** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Contract**.

- No agent or other person, except an authorized representative of **Aetna**, has authority to waive any condition or restriction of this **Contract**, to extend the time for making a payment, or to bind **Aetna** by making any promise or representation or by giving or receiving any information. No change in this **Contract** shall be valid unless evidenced by an endorsement to it signed by an authorized representative of **Aetna**.

  This **Contract**, including the Enrollment Form, Cover Sheet, including the *Schedule of Benefits* and any amendments, endorsements, inserts, or attachments, constitutes the entire **Contract** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral. There are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth in this **Contract**. No supplement, modification or waiver of this **Contract** shall be binding unless executed in writing by authorized representatives of the parties.

  All statements made by the **Contract Holder** or a **Member** shall be deemed representations and not warranties. No written statement made by a **Member** shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to the **Member** or his or her beneficiary, or the person making the claim.

  This **Contract** is subject to all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **Aetna**, and this **Contract** shall be deemed to be amended to conform therewith at all times. This **Contract** may be changed at any time for any other reason by agreement between **Aetna** and the **Contract Holder**, without the consent of any **Member** or other person. Except as detailed below, any amendments to this **Contract** shall be in writing and must be approved and executed by authorized representatives of both the **Contract Holder** and **Aetna**. No other individual has the authority to modify this **Contract**; waive any of its provisions, conditions, or restrictions; extend

the time for making a payment; or bind **Aetna** by making any other commitment or representation or by giving or receiving any information. No change in this **Contract** shall be valid unless evidenced by an endorsement, signed by an authorized representative of **Aetna**.

Formal acceptance of an amendment to this **Contract** by the **Contract Holder** shall not be required if:

- The change was requested by either the **Contract Holder** or **Aetna** and is agreed to in writing by the other; or
- The change is required to bring the **Contract** into conformance with any applicable federal or state law or regulation, or ruling of the jurisdiction in which the **Contract** is delivered; or
- The **Contract Holder** makes payment of any applicable **Premium** on and after the effective date of such amendment.

- This **Contract** has been entered into and shall be construed according to applicable state and federal law.

Discount Programs

Discount Arrangements:

From time to time, **Aetna** may offer, provide, or arrange for discount arrangements or special rates from certain service **Providers** such as pharmacies, optometrists, dentist, alternative medicine, wellness and healthy living providers to **Member**s or persons who become **Member**s. Some of these arrangements may be available through third parties who may make payments to **Aetna** in exchange for making these services available. The third party service **Providers** are independent contractors and are solely responsible to **Members** for the provision of any such goods and/or services. **Aetna** reserves the right to modify or discontinue such arrangements at any time. These discount arrangements do not constitute benefits provided under the **Contract**. There are no benefits payable to **Member**s nor does **Aetna** compensate **Provider**s for services they may render.

Wellness Incentives:

In order to encourage **Members** to access certain medical services when deemed appropriate by the **Member**, in consultation with the **Member's Physician** or other service **Provider**, **Aetna** may, from time to time, offer to waive or reduce a **Copayment**, **Coinsurance**, and/or a **Deductible** otherwise required under this **Contract** or offer coupons or other financial incentives. **Aetna** has the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the **Members** to whom these arrangements are available.

Proof of Loss and Claims Payment

*The following provisions apply only as they relate to breast pump services and supplies obtained from a **Non-Participating Provider** and contraceptives obtained from a **pharmacy** under the Preventive Care Benefit. For more information refer to the Preventive Care Benefit earlier in this amendment.*

- **Proof of Loss:** Written proof of loss must be furnished to **Aetna** within 90 days after a **Member** incurs expenses for **Covered Benefits**. Failure to furnish the proof of loss within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give the proof

of loss within 90 days, provided the proof of loss is furnished as soon as reasonably possible. However, except in the absence of legal capacity of the claimant, the proof of loss may not be furnished later than one year from the date when the proof of loss was originally required. A proof of loss form may be obtained from **Aetna** or the **Contract Holder**. If the **Member** does not receive such form before the expiration of 15 working days after **Aetna** receives the request, the **Member** shall be deemed to have complied with the requirements of this **Contract** upon submitting within the time fixed in this **Contract** written proof covering the occurrence, character and extent of the loss for which claim is made.

- **Time for Payment of Claim:** Benefits payable under this **Contract** will be paid promptly after the receipt by **Aetna** of satisfactory proof of loss. If any portion of a claim is contested by **Aetna**, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss by **Aetna**.

Change of Residence

It is your responsibility to notify **Aetna** within 31 days if you change your residence. If you move outside of the State of Maine and **Aetna** has a plan in that state, **Aetna** will issue to you a **Contract** with comparable coverage as of the beginning of the **Premium Period** in which the change occurs, without a lapse in coverage. The premium for the new coverage will be based upon the premium rates for your new state of residence, and the then ages of the covered dependents. If you would like increased coverage, Aetna may review your health information again and this may result in a higher rate.

If you move within the **Service Area**, premium rates will be adjusted, if necessary, to adjust to your new address and the current ages of your covered dependents, effective at the beginning of the **Premium Period** following the change of residence.

PREMIUM PAYMENT

The first premium payment for this **Contract** is due on or before your Effective Date. Your subsequent premium payment shall be due on the 1st of each month based on your Effective Date. Each premium payment is to be paid to **Aetna** on or before the due date. Your premium becomes overdue following the last day of the **Premium Period**.

Note to State Consultant: Language assumes that prompt pay penalties will not apply during the three month grace period applicable to members receiving premium tax credit.

A grace period of 30 days will be granted for each premium payment due after the first premium payment, provided that a grace period of three months will be granted if an individual receiving an advance payment of the premium tax credit has previously paid at least one full month's premium during the benefit year. The coverage will remain in force during the grace period, provided that if for an individual receiving an advance payment of the premium tax credit, **Aetna** may pend claims for services rendered during the second and third months of the grace period, in which case **Aetna** shall notify you and providers of the possibility that such claims may not be paid.

If your premium is not paid by the end of the grace period, your coverage may be cancelled as of the last day of the grace period, without any previous notification unless expressly required by state law. If your grace period was three months because you receive advanced payment of the premium tax credit, your coverage may be cancelled and coverage end as of the end of the last day of the first month of the grace period. **Aetna** has the right to require the return of any payments for claims paid during the grace period for which premium was not received. If this **Contract** is terminated for nonpayment and you request reinstatement, all past due and current premium must be paid in full in order to be reinstated. **Aetna** may decline reinstatement at our discretion.

In the event a premium payment check is returned or dishonored by the bank as non-payable to **Aetna** for any reason, you may be responsible for an additional charge.

Your premium rate will not change for the initial month of this **Contract** provided that there are no changes to this **Contract**, including your area of residence, benefit plan or addition of dependents. However, if there is a change in law or regulation or a judicial decision that has an impact on the cost of providing your covered benefits under this **Contract**, we reserve the right to change your premium rate during this guarantee period.

Your premium rate is based upon factors such as:

- Type and level of benefit plan;
- Your age and the ages of covered dependents;
- The number of covered persons;
- Tobacco use; and
- Place of residence.

Premium rates are expected to change over time as the cost of healthcare services change. We have the right to change premium rates at any time in the future, subject to applicable regulatory review. Each premium will be based on the rates in effect on that premium due date.

In the event of any changes in premium rates, payment of the premium by the **Contract Holder** shall serve as notice of the **Contract Holder's** acceptance of such changes.

We issued this policy to you in exchange for premium paid by you. **Aetna** reserves the right to not accept premium paid by third parties.

DEFINITIONS

The following words and phrases when used in this **Contract** shall have, unless the context clearly indicates otherwise, the meaning given to them below:

Aetna
Aetna Health Inc., is a Maine corporation that was issued a certificate of authority by the Maine Bureau of Insurance to operate as a Health Maintenance Organization.

Ambulance
A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Autism Spectrum Disorder
This means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder--Not Otherwise Specified.

Behavioral Health Provider
A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Biosimilar Prescription Drug(s)
A biological **Prescription Drug** that is highly similar to a U.S. Food and Drug Administration (FDA) – licensed reference biological **Prescription Drug** notwithstanding minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the highly similar biological **Prescription Drug** and the reference biological **Prescription Drug** in terms of the safety, purity, and potency of the drug, as defined in accordance with U.S. Food and Drug Administration (FDA) regulations.

Body Mass Index
A practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand-name Prescription Drug(s)
Prescription drugs and insulin with a proprietary name assigned to it by the manufacturer or distributor and so indicated by MediSpan or any other similar publication designated by **Aetna**.

Contract
The Individual Advantage **Contract** between **Aetna** and the **Contract Holder**, including the Enrollment Form, including the *Schedule of Benefits*, any riders, and any amendments, endorsements, inserts, or attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority, which outlines coverage for a **Subscriber** and **Covered Dependents**.

Contract Holder
A **Subscriber** who agrees to remit the **Premiums** for coverage under this **Contract** payable to **Aetna**. The **Contract Holder** shall act only as an agent of **Aetna Members** in the **Contract Holder's** family, and shall not be the agent of **Aetna** for any purpose.

Contract Year
A period of 1 year commencing on the **Contract Holder's Effective Date of Coverage** and ending at 12:00 midnight on the last day of the 1 year period.

Copayment
The specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the *Schedule of Benefits*. **Copayments** may be changed by **Aetna** upon 30 days written notice to the **Contract Holder**.

Cosmetic Surgery
Any surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.

Covered Dependent
Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Contract** has enrolled in **Aetna**, and is subject to **Premium** requirements set forth in the Premiums section of the **Contract**.

Covered Benefits
Those **Medically Necessary Services** and supplies set forth in this **Contract**, which are covered subject to all of the terms and conditions of th**is Contract**.

Custodial Care
Services and supplies that are primarily intended to help a **Member** meet their personal needs. Care can be **Custodial Care** even if it is prescribed by a **Physician**, delivered by trained medical personnel, or even if it involves artificial methods (or equipment) such as feeding tubes, monitors, or catheters. Examples of **Custodial Care** include, but are not limited to:

- Changing dressings and bandages, periodic turning and positioning in bed, administering oral medication, watching or protecting a **Member.**
- Care of a stable tracheostomy, including intermittent suctioning.
- Care of a stable colostomy/ileostomy.
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
- Care of a stable indwelling bladder catheter, including emptying/changing containers and clamping tubing.
- Respite care, adult (or child) day care, or convalescent care.

- Helping a **Member** perform an activity of daily living, such as: walking, grooming, bathing, dressing, getting in and out of bed, toileting, eating, or preparing food.
- Any services that an individual without medical or paramedical training can perform or be trained to perform.

Deductible
The first payments up to a specified dollar amount which a **Member** must make in the applicable calendar year for **Covered Benefits**.

Designated Network Providers
Participating Providers that are shown in the **Aetna** directory and in DocFind as Choose and Save, Savings Plus, or ACO Plan Name, or Aetna Whole Health **Providers** for the plan.

Detoxification
The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.

Durable Medical Equipment (DME)
Equipment, as determined by **Aetna**, which is:
- made for and mainly used in the treatment of a disease or injury;
- made to withstand prolonged use;
- suited for use while not confined as an inpatient in the **Hospital**;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature; and
- not for exercise or training.

Effective Date of Coverage
The commencement date of coverage under this **Contract** as shown on the records of **Aetna**.

Emergency Service
Professional health services that are provided to treat a **Medical Emergency**.

E-visit
A telephone or internet-based consult with a **provider** that has contracted with **Aetna** to offer these services.

Experimental or Investigational Procedures
Services or supplies that are, as determined by **Aetna**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or

- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or
  It is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or
- It is provided or performed in special settings for research purposes.

Generic Prescription Drug(s)

Prescription drugs and insulin, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by MediSpan or any other similar publication designated by **Aetna**.

Habilitation

Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Professional(s)

A **Physician** or other professional, including a nurse practitioner, nurse midwife, nurse first assistant or dental hygienist, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.

Homebound Member

A **Member** who is confined to their place of residence due to an illness or injury which makes leaving the home medically contraindicated or if the act of transport would be a serious risk to their life or health.

Examples where a **Member** would not be considered homebound are:

- A **Member** who does not often travel from home because of feebleness and/or insecurity brought on by advanced age (or otherwise).
- A wheelchair bound **Member** who could safely be transported via wheelchair accessible transport.

Home Health Care Agency

An agency that meets all of the following requirements:

- Mainly provides skilled nursing and other therapeutic services;
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy;
- Has full-time supervision by a **physician** or an **R.N.**;

- Keeps complete medical records on each person;
- Has an administrator; and
- Meets licensing standards.

Home Health Services
Those items and services provided by **Participating Providers** as an alternative to hospitalization, and coordinated and precertified by **Aetna**.

Hospice Care
A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **Aetna**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than [6-24] months to live.

Hospital(s)
An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **Aetna** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.

Infertile or **Infertility**
A disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 35 or older).

Institute of Excellence™ (IOE)
One of a network of facilities specifically contracted with by **Aetna** to provide certain **Transplants** to **Members**. A facility is considered a **Participating Provider** only for those types of **Transplants** for which it has been specifically contracted.

Interested Parties
Means **Contract Holder**, including any and all affiliates, agents, assigns, employees, heirs, personal representatives or subcontractors of an **Interested Party**.

L.P.N.
A licensed practical or vocational nurse.

Mail Order Pharmacy
An establishment where **Prescription Drugs** are legally given out by mail or other carrier.

Maximum Prescription Drug Out-of-Pocket Limit
The maximum amount of **Copayments** plus the **Prescription Drug Deductible Amount** and the difference in cost between a requested **Brand Name Prescription Drug** and an available **Generic Prescription Drug** equivalent as described in the *Schedule of Benefits* that any one **Member** or family must pay during a calendar year. **Aetna** will pay 100% of the **Negotiated Charge** for covered outpatient **Brand Name** and **Generic Prescription Drugs** for the remainder of that calendar year..

Medical Community
A majority of **Physicians** who are Board Certified in the appropriate specialty.

Medical Emergency
The existence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

Medical Services
The professional services of **Health Professionals,** including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.

Medically Necessary, Medically Necessary Services, or Medical Necessity
Health care services that Aetna determines a **physician** or other health care provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms, and that **Aetna** determines are:

- In accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease;
- Not primarily for the convenience of the patient, **physician**, other health care or dental provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

"Generally accepted standards of medical practice" means:
- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Consistent with the standards set forth in policy issues involving clinical judgment

Member(s)
A **Subscriber** or **Covered Dependent** as defined in this **Contract**.

Mental Disorders
This is an illness commonly understood to be a **Mental Disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **Behavioral Health Provider** such as a **Psychiatrist**, a psychologist or a psychiatric social worker.

The following conditions are considered a **Mental Disorder** under this plan:
- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive Mental Developmental Disorder (including Autism).
- Psychotic Disorders/Delusional Disorder.

- Schizo-affective Disorder.
- Schizophrenia.

Also included is any other mental condition which requires **Medically Necessary** treatment.

Morbid Obesity

A Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid medical condition, including significant cardiovascular disease, sleep apnea, or uncontrolled type-2 diabetes.

National Medical Excellence Program

Coordinating **Aetna** services team for **Transplant** services and other specialized care.

Negotiated Charge

As to Health Coverage, (other than Prescription Drug Coverage):
The **Negotiated Charge** is the maximum charge a **Participating Provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Coverage:
The **Negotiated Charge** is the amount **Aetna** has established for each **Prescription Drug** obtained from a **Participating Pharmacy** under this plan. This **Negotiated Charge** may reflect amounts **Aetna** has agreed to pay directly to the **Participating Pharmacy** or to a third party vendor for the **Prescription Drug**, and may include an additional service or risk charge set by **Aetna**.

The **Negotiated Charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna,** an affiliate or a third party vendor and a drug manufacturer for any **Prescription Drug**, including **Prescription Drugs** on the **Preferred Drug Guide (Formulary)**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **Prescription Drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **Negotiated Charge** under this plan.

Network Pharmacy

Is a retail **Pharmacy**, mail order **Pharmacy** or **Specialty Network Pharmacy** that has entered into a contractual agreement with **Aetna**, an affiliate, or a third party vendor, to furnish services and supplies for this plan. The appropriate **Pharmacy** type may also be substituted for the word **Pharmacy**. (E.g. retail **Network Pharmacy,** mail order **Network Pharmacy** or **Specialty Network Pharmacy**).

Non-Designated Network Providers

These are **Participating Providers** that are shown in the **Aetna** directory and in DocFind for the plan.

Non-Hospital Facility

A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.

Non-Participating Providers

These are **Providers** that are not **Participating Providers**.

Non-Preferred Drug (Non-Formulary)
is a **Prescription Drug** or device that is not listed in the **Preferred Drug Guide (Formulary)**. This includes **Prescription Drugs** and devices on the **Preferred Drug Guide Exclusions List** that are approved by medical exception.

Partial Hospitalization
The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. The program must meet these tests:

- It is carried out in a **hospital**; **psychiatric hospital** or **residential treatment facility**; on less than a full-time inpatient basis;
- It is in line with accepted medical practice for the condition of the person;
- It does not require full-time confinement;
- It is supervised by a **psychiatrist** who weekly reviews and evaluates its effect;

Participating
A description of a **Provider** that has entered into a contractual agreement with **Aetna** for the provision of services to **Members**.

Participating Infertility Specialist
A **Specialist** who has entered into a contractual agreement with **Aetna** for the provision of **Infertility** services to **Members**.

Physician(s)
A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "**physician**" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by **substance abuse** or a **mental disorder**; and
- A **physician** is not you or related to you.

Also, to the extent required by law, a practitioner who performs a service which coverage is provided when it is performed by a **physician**. These include, but may not be limited to the following:

- Acupuncturist;
- Chiropractor;
- Optometrist;

- Certified Registered Nurse Anesthetists;
- Certified Nurse Midwives;
- Certified Nurse Practitioner;
- Registered Nurse First Assistant;
- Social Workers;
- Psychiatric Nurses.
- Licensed Clinical Professional Counselors
- Dental Hygiene Therapists
- Pastoral Counselors
- Marriage and Family Therapists

Precertification, Precertify, Precertified

A process where **Aetna** is contacted before certain services are provided, such as **Hospitalization** or outpatient services, or **Prescription Drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **Covered Benefits** under the plan. It is not a guarantee that benefits will be payable if, for example, it is determined at the time the claim is submitted that you were not eligible for benefits at that time.

Premium Period
The **Premium Period** is the span of time which begins at either the 1st of the month based on your Effective Date and ends 30 days later.

Preferred Drug (Formulary)
A **Prescription Drug** or device that is listed on the **Preferred Drug Guide (Formulary)**.

Preferred Drug Guide (Formulary)
A listing of **Prescription Drugs** established by **Aetna** or an affiliate, which does not cover all **Prescription Drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **Preferred Drug Guide (Formulary)** will be available upon your request or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Preferred Drug Guide Exclusions List
A list of **Prescription Drugs** in the **Preferred Drug Guide (Formulary)** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna** or an affiliate.

Preferred Network Pharmacy
A **network retail pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** to you.

Premium Period
The **premium period** is the span of time which begins at either the 1st of the month based on your Effective Date and ends 30 days later.

Prescription
*As to **Prescription Drugs**:*
A written order for the dispensing of a **Prescription Drug** by a **Provider**. If it is a verbal order, it must promptly be put in writing by the **Pharmacy**.

As to vision care:
A written order for the dispensing of **Prescription** lenses or **Prescription** contact lenses by an ophthalmologist or optometrist.

Prescription Drug
A drug, biological, or compounded **Prescription** which, by State and Federal Law, may be dispensed only by **Prescription.** This includes:

> An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional.

Prescription Drug Deductible Amount
The specified amount of **Covered Benefits** for **Prescription Drug**s which a **Member** or a family unit (as the case may be) is required to pay before **Aetna** pays any benefits. **Covered Benefits** which are used in satisfying the **Prescription Drug Deductible Amount** must be incurred and applied to such **Prescription Drug Deductible Amount** within the applicable calendar year**.** This amount will not reflect or include

any amount **Aetna**, an affiliate or a third party vendor, may receive under a rebate arrangement between **Aetna**, an affiliate or a third party vendor, and a drug manufacturer for any drugs, including any drugs on the **Drug Formulary**.

Primary Care Physician (PCP)

A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.

Provider(s)

A **Physician**, **Health Professional**, **Hospital**, **Skilled Nursing Facility**, home health agency or other recognized entity or person licensed to provide **Hospital** or **Medical Services** to **Members**.

Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of **Substance Abuse** or **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **Hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **Psychiatrist** who is responsible for patient care and is there regularly.
- Is staffed by **Psychiatrists** involved in care and treatment.
- Has a **Psychiatrist** present during the whole treatment day.
- Provides, at all times, **Psychiatric** social work and nursing services.
- Provides, at all times, **Skilled Nursing Services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **Psychiatrist**.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of **Substance Abuse** or **Mental Disorders**.

Psychiatrist

This is a **Physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of **Substance Abuse** or **Mental Disorders**.

Residential Treatment Facility (Mental Disorders)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by **Aetna** or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating **mental disorders**:

- A **Behavioral Health Provider** must be actively on duty 24 hours per day for 7 days a week.
- The patient must be treated by a **Psychiatrist** at least once per week.
- The medical director must be a **Psychiatrist**.

Residential Treatment Facility (Substance Abuse)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for substance abuse residential treatment programs. And is credentialed by **Aetna** or accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Chemical Dependence Residential Treatment Programs:

- A **behavioral health provider** or an appropriately state certified professional (Certified Drug and Alcohol Counselor -- CADC; Certified Addiction Counselor -- CAC, etc.) must be actively on duty during the day and evening therapeutic programming.
- The medical director must be a **Physician** who is an addiction **Specialist**.

In addition to the above requirements, for Chemical Dependence **Detoxification** Programs within a residential setting:

- An **R.N.** must be onsite 24 hours per day for 7 days a week within a residential setting.
- Residential care must be provided under the direct supervision of a **physician**.

Respite Care

Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.

Retail Pharmacy

A community **pharmacy** which has contracted with **Aetna**, an affiliate, or a third party vendor, to provide

covered outpatient **Prescription Drugs** to you.

Self-injectable Drug(s)

Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

Service Area

The geographic area established by **Aetna** and approved by the appropriate regulatory authority.

Skilled Care

Medical care that requires the skills of technical or professional personnel.

Skilled Nursing

Services that require the medical training of and are provided by a licensed nursing professional and are not **Custodial Care**.

Skilled Nursing Facility

An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing **Skilled Nursing** care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. **Skilled Nursing Facility** does not include institutions which provide only minimal care, **Custodial Care** services, ambulatory or part-time care services, or institutions which primarily provide for the care and treatment of **Mental Disorder** and **Substance Abuse**. The facility must qualify as a **Skilled Nursing Facility** under Medicare or as an institution accredited by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, the Commission on the Accreditation of Rehabilitative Facilities, or as otherwise determined by the health insurer to meet the reasonable standards applied by any of the aforesaid authorities. Examples of **Skilled Nursing Facilities** include Rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a **Hospital** designated for Skilled or Rehabilitation services.

Specialist(s)

A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

Specialty Care

Health care services or supplies that require the services of a **Specialist**.

Specialty Care Prescription Drugs

These are **Prescription Drugs** that include [self-] injectable, infusion and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as:

- Cancer
- Rheumatoid arthritis
- Hemophilia
- Human immunodeficiency virus infection

- Multiple sclerosis

You can access the list of these **Specialty Care Prescription Drugs** by calling the toll-free Member Services number on your member ID card or by logging on to your Aetna Navigator® secure member website at www.Aetna.com. The list also includes **Biosimilar Prescription Drugs**.

Specialty Network Pharmacy
A network of pharmacies designated to fill **Prescriptions** for **Self-injectable Drugs and Specialty Care Prescription Drugs**.

Step Therapy Program
A form of **precertification** under which certain **Prescription Drug**s will be excluded from coverage**,** unless a first-line therapy drug(s) is used first by the **Member**. The list of **Step Therapy** drugs is subject to change by **Aetna**. An updated copy of the list of drugs subject to step therapy shall be available upon request by the **Member** or may be accessed at the **Aetna** website, at www.aetna.com.

Subscriber
A person who meets all applicable eligibility requirements as described in this **Contract** has enrolled in **Aetna**, and is subject to **Premium** requirements as set forth in the *Premiums* section of the **Contract**.

Substance Abuse
Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Abuse Rehabilitation
Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individualized treatment plans.

Surgery or Surgical Procedure
The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Telemedicine
A telephone or internet-based consult with a **provider** that has contracted with **Aetna** to offer these services.

Therapeutic Drug Class
A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or injury.

Tier 1A
A group of medications determined by **Aetna** that may be available at a reduced **copayment/coinsurance** and are noted in the **Preferred Drug Guide (Formulary)** on the **Aetna** website at www.Aetna.com/formulary.

Tier 1
A group of medications determined by **Aetna** that may be available at a reduced **copayment/coinsurance** and are noted on the **Preferred Drug Guide (Formulary)** on the **Aetna** website at www.Aetna.com/formulary.

Totally Disabled or Total Disability
A **Member** shall be considered **Totally Disabled** if:

- The **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments; or
- The **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

Transplant
Replacement of solid organs; stem cells; bone marrow or tissue.

Transplant Occurrence
Considered to begin at the point of authorization for evaluation for a **Transplant**, and end on the later of:

- 30 days from the date of the **Transplant**; or
- upon the date the **Member** is discharged from the **Hospital** or outpatient facility for the admission or visit(s) related to the **Transplant**.

Urgent Care
Non-preventive or non-routine health care services which are **Covered Benefits** and are required in order to prevent serious deterioration of a **Member's** health following an unforeseen illness, injury or condition if: (a) the **Member** is temporarily absent from the **Aetna Service Area** and receipt of the health care service cannot be delayed until the **Member** returns to the **Aetna Service Area**; or, (b) the **Member** is within the **Aetna Service Area** and receipt of the health care services cannot be delayed until the **Member's Primary Care Physician** is reasonably available.

Urgent Care Facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.

Walk-in Clinic

A **Participating** free-standing health care facility. They are an alternative to a **Participating Physician's** office visit for treatment of:

- Unscheduled, non-**Medical Emergency** illnesses and injuries**;**
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a **Participating Physician**.

Neither of the following should be considered a **Walk-in Clinic**:

- An emergency room; nor
- The outpatient department of a **Hospital**.